

**HEALING MINISTRY, CONFLICT AND METHODISM: THE CASE OF
MABELREIGN, EPWORTH AND MBARE SOCIETIES OF THE METHODIST
CHURCH IN ZIMBABWE (MCZ)**

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DECLARATION

This thesis is submitted in fulfilment of the requirements for the degree of **DOCTOR OF PHILOSOPHY**, in the **SYSTEMATIC THEOLOGY** at the University of KwaZulu-Natal, Pietermaritzburg, South Africa.

I, **MARTIN MUJINGA**, declare that the research reported in this thesis, except where otherwise indicated, and is my original research. I also declare that this thesis has not been submitted for any degree or examination at any other university. In addition, I declare that this thesis does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons. I further declare that this thesis does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, their words have been re-written but the general information attributed to them has been referenced, and where their exact words have been used, then their writing has been placed in italics and inside quotation marks and referenced.

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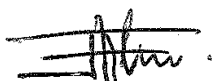
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DEDICATION

This thesis is dedicated to my wife and life Meloreen Mujinga, my mother Letty Simon (Nee Chakadenga), the late grandmother Keresia Chakadenga, and my three children Chikomborero, Ropafadzo and Nyasha.

ACKNOWLEDGEMENTS

First, I thank God for his grace that saw me through this academic pilgrimage. I also thank the Methodist Church in Zimbabwe (MCZ) for granting me the opportunity to study for the Doctor of Philosophy degree at the University of KwaZulu-Natal in South Africa as a fulltime candidate. I also extend my gratitude to the World Church Office of the Methodist Church Britain through their Scholarship and Leadership Training (SALT) programme for awarding me a scholarship to pursue my studies. The commitment to partnership of the MCZ and SALT on my education cannot be overemphasized. It was really an honour to be selected from among many Methodist ministers in Africa for this scholarship. I also want to thank my Supervisor Prof. Roderick Hewitt for his wisdom and patience regarding my work. He worked tirelessly with me on this project from the beginning to the very end. I am also indebted to Dr Chammah J. Kaunda who came on board in my research space when I needed him most. His contributions to this research will ever be cherished. It was not a smooth road, but the intellectual contribution of these two esteemed men was above the situation. My appreciation also goes to Prof. Herbert Moyo my pastor, mentor and friend in the School of Religion, Philosophy and Classics. Prof. Moyo offered me an opportunity to be a Graduate Teaching Assistant in his field of Practical Theology where my topic had some major links. This opportunity shaped the scope of my thesis especially during our discussions with him and his students during lectures.

Most of the resources for this research were obtained from Seth Mokitimi Methodist Seminary library and archives, The National Archives of Zimbabwe, MCZ archives, church leaders and members of Mabelreign, Epworth and Mbare (MEM) societies who were interviewed. Thank you all for allowing me to tap from your rich reservoirs of knowledge. Special mention goes to the former MCZ members of MEM societies for opening their doors for me and for allowing me to interview them about their past faith in the MCZ. I am also indebted to Bishop Ivan Abrahams the World Methodist Council General (WMC) Secretary and Prof Simangaliso Kumalo for their facilitation for me to have financial aid during my studies. The stipend from the WMC of a Research Assistant and SMMS through my work as an Adjunct Lecturer reinvigorated me to pursue my studies with less financial pressure. I also wish to thank my beloved wife Meloreen and my children Chikomborero, Ropafadzo and Nyasha for their unwavering support. The support of these family members during my studies gave me hope every day. I cherished their love, care and support which made my studies a success.

ABBREVIATIONS AND GLOSSARY OF ACRONYMS

AAC	African Apostolic Church
AIC	African Indigenous / Initiated Churches
AIDS	Acquired Immunodeficiency Syndrome
AFM	Apostolic Faith Mission
AIR	African Indigenous Religions
AR	African Religions
ATR	African Traditional Religion (s)
BACW	Bethsaida Apostolic Church Website
BSAC	British South Africa Company
CHM	Christian Healing Ministry
ETC	Epworth Theological College
GRJ	Guta Ra Jehovah
HAM	Harvest Apostolic Ministries
HIV	Human Immunodeficiency Virus
MCA	Methodist Church Archives
MCB	Methodist Church Britain
MEM	Mabelreign Epworth and Mbare
MCSA	Methodist Church of Southern Africa
MCZ	Methodist Church in Zimbabwe
MeDRA	Methodist Development and Relief Agency
MMS	Methodist Missionary Society
NAZ	National Archives of Zimbabwe
SMMS	Seth Mokitimi Methodist Seminary
PHD	Prophetic Healing and Deliverance Ministries
RCC	Roman Catholic Church
RM	Ruwadzano/Manyano
SADC	Southern African Development Community
UFIC	United Family International Church
UMC	United Methodist Church
UTC	United Theological College
UNIAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VOGAC	Voice of God Apostolic Church
WHO	World Health Organization
WJW	Works of John Wesley
ZAOGA (FIF)	Zimbabwe Assemblies of God Africa (Forward in Faith)
ZBCTV	Zimbabwe Broadcasting Corporation Television
ZCHO	Zimbabwe Church related Hospitals Organizations
ZINATHA	Zimbabwe National Traditional Healers Association
ZHPF	Zimbabwe Homeless People Federation

ABSTRACT

This study focuses on a critique of healing ministry, conflict and Methodism: the case of Mabelreign, Epworth and Mbare (MEM) societies of the Methodist Church in Zimbabwe (MCZ). The project seeks to find out the nature of the healing ministry practiced by MCZ and the extent to which MEM societies respond meaningfully to the healing needs of their members within the local cultural context. The research uses the missio-cultural framework as postulated by Roderick Hewitt (2012), with the aim of analysing how mission and culture¹ can come into dialogue in the theology of healing ministry in MCZ. Using the inculturation lens of Edward Antonio (2006) to converse with this discourse, the thesis argues that healing ministry is intrinsic to the missional calling of the MCZ in its given cultural milieu, however, this mission has been severely neglected because it has not been taken seriously in the church's ministry. This situation has resulted in dual membership, syncretism and/or the total transfer of membership from MCZ to either African Initiated Churches (AICs) or newer Pentecostal churches.

The research notes that healing ministry in the MCZ dates back to the time of John Wesley in the eighteenth century England and his hermeneutical emphasis on biblical texts that gave priority to the healing ministry of Jesus amongst the poor. Wesley's theology was grounded in healing ministry, however, the Methodism that was transported and transplanted to Zimbabwe by the missionaries in 1891 did not fit in the African culture, thereby causing missio-cultural conflicts which led to the formation of six AICs that separated from MCZ since the 1950s. The empirical study uses the phenomenological method to observe and to draw findings from both MCZ leaders and ordinary members of the selected societies through interviews. The research concludes by challenging MCZ to revisit its theology of healing since this was the foundation of early Methodism. In spite of some external factors influencing healing ministry in the MCZ, the church needs to give theological clarity to its understanding and practice of healing because failure to do so will risk creating division among its clergy and laity. This is especially so because the weak socioeconomic conditions within Zimbabwe have pushed many people into poverty and this has impacted negatively on the physical, psychological, spiritual and economic health of many citizens. This is exacerbated by religious contestation that MCZ has found itself in, whereby members are now more concerned about their healing than loyalty to their church

¹ I am aware that the word culture has many interpretations and all forms of human evolve from culture. This makes the word to have various interpretations. In this research, the word culture will be used with specific reference to African culture especially Zimbabwean culture given that this is the focus of the research.

membership. If MCZ has to give its members the resource of wholesome living, then healing ministry should be at the centre of its mission.

Geographical map of Harare and the location of Mabelreign, Epworth and Mbare



Fig. 1. Map of Harare (Epworth Maps 2013).

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CHAPTER ONE: INTRODUCTION

1.1 Introducing the Research Problem

The subject of healing ministry² is one of the most significant issues affecting the authenticity of the ministry and mission of MCZ. In church meetings, the phenomenon has drawn much attention, while in the general administration of the church, it has caused some notable conflicts. The ongoing divisive debates on the healing ministry have led to problems in many churches, starting with conflictive relationships among the clergy members, which have caused divisions within the ministry and mission of the church. Some ministers have advertised their healing gifts among members of the Church and present themselves as ‘super ministers’, and some of them have changed the traditional title prescribed for clergy of “reverend”, bequeathed upon them by the MCZ, to the preferred charismatic titles of apostle, evangelist, and prophet (Minutes of the Methodist Church in Zimbabwe Conference 2013:13). The 2013 Conference³ noted this development with grave concern because these titles are contrary to the MCZ clergy rules and regulations (:13). The Conference requested the District Bishops⁴ to address the issue. In assigning the District Bishops to address this issue, the conference instructed them to act urgently and resolve the confusion that has characterized the church and to reprimand the concerned ministers who are involved (:13).

In 2014, Conference passed a resolution on healing and deliverance, confirming that the church should return to “the original healing and deliverance” practiced by Methodist since the issue of healing and deliverance was dividing the church (Minutes of the Methodist Church in Zimbabwe Conference 2014:12). However, the conference did not give any reference to this original healing and deliverance ministry. The biggest question is, does the word “original” refer to how John Wesley practiced the healing ministry? Does it refer to the healing ministry in the British Methodist Church where the MCZ came from? Does the

² In this research, healing ministry refers to healing that takes place through pastoral care, fellowship, sacraments, medical practices, prayer, exorcism and counselling that is practised by the MCZ (see John Wesley in Dickinson 1995:175; Anderson, 2007:37; MacNutt 1988:162; Hughes 2007:5; Iyakaremye 2013).

³ Conference is the governing board of the MCZ and is the final authority for interpretation of the doctrinal standards of the Church (MCZ *Deed of Church Order and Standing Orders* 2007. 12.1, 2 p 7). The Conference is attended by representatives from the District Synod and Conference elected delegates from Church leadership. It is constituted by equal numbers of ministers and laypeople. The Conference of the Methodist Church in Zimbabwe meets to, among other responsibilities, deal with the governance, management and administration of the Church affairs (*Deed of Church Order and Standing Orders* 2007. 26. pg. 17).

⁴ The District Bishop, according to the MCZ, is the minister who presides over the Synod of the relevant district (MCZ *Deed of Church Order and Standing Orders*. 2007.103).

word refer to the missionary understanding of healing or the understanding of healing by the post-colonial MCZ? The conference also noted that some ministers were using the healing and deliverance platforms to attack fellow ministers (Minutes of the MCZ Conference 2014:12). This practice was agreed to be causing divisions in the church.

The second challenge is the extension of these bad relationships to the laity. The laity praised the ‘super ministers’ and accused those ministers whom they felt were doing maintenance type of ministry as not being able to meet the members’ healing needs. A case in point is the issue of ‘dual membership’ that was discussed in the MCZ Conference of 2011. During the debates in the Lay Session⁵ of Conference, delegates had conflicting ideas on the position of dual membership. In analysing dual membership, Adogame *et al* (2008: 197), point out that a large number of Christians join Pentecostal Churches because they are disappointed with their former churches. They complained that the worship is dry, there is no manifestation of ‘spiritual power’, and there is no sufficient prayer time in the mainline churches. These scholars add that people end up seeking younger, more zealous and more spiritual fellowships where their healing sensations are quenched. Adogame *et al* (2008: 198) further argues that, “some congregants from the protestant churches consequently adopted a system of plural belonging by maintaining membership of their mother churches, at the same time worship with one of the many spiritual churches around” (see also Bertucci 2007).

At the 2013 MCZ Conference, the Lay delegates were caught in a dilemma over dual church membership. On the one hand, one group felt that dual membership was not irregular because members of the church ‘simply go out’ to other churches to get what they want and then return to their local congregation (Minutes of MCZ Conference 2011:24). However, on the other hand, some argued that such behaviour was un-Methodist (:24). The churches that were mentioned by the Lay Session included both the African Initiated Churches⁶ and

⁵ Lay Session of Conference refers to the session that is attended by the lay Conference delegates while the ministers will be attending the Ministerial Session. After the two separate session, the Conference reconvenes, forming the Representative Session of Conference where resolutions from both sessions will be debated. The session is presided over by the Connexional Lay President (MCZ *Deed of Church Order and Standing Orders* 2007.103. p. 30), (MCZ *Deed of Church Order and Standing Orders*. 26 B.a-o, p. 14-16).

⁶ According to Chitando (2005), “there has been a considerable debate over the most appropriate term although African Initiated Churches enjoyed a lot of currency up to the 1990s, other competing terms have since gained ground. These includes African Initiated, indigenous, and Instituted Churches. The terms generally means that the churches were found in Africa by Africans and for Africans” (See also Berends 1993; Daneel 1970; Ngada and de Toit 1998; Gundani 2001; Vengeyi 2011; and Mawire 2015). In this research, I will use the term African Initiated Churches with the view that other terms demean AICs as inferior and mainline churches as superior. The use of the term Initiated in this thesis has been concluded to be neutral. Other terms that could

the New Charismatic movements. Some members would go as far as approaching African Traditional healers to perform healing rites. Those lay conference delegates who accused ministers of ‘incompetency’ in ministry claimed that the reason some members went for healing elsewhere was because their healing and deliverance needs were not seriously addressed by the ministers in the MCZ (:24). The Lay Session also noted with concern the despairing attitude of some ministers during the healing and deliverance session at the One Hundred and Twentieth year’s celebration of the MCZ in Bulawayo. The session laments that “hundreds of people wanted to be prayed for; but many of ‘our ministers’ were loitering about or socializing and only a few were attending to the healing needs of the people” (:24). Some lay members of Conference attributed this dismissive behaviour to be one of the causes of dual membership. It is worth noting that Zimbabweans have turned to Pentecostal spirituality to cope with their challenges of poverty, crime and high rates of unemployment. They have reduced their allegiance to missionary Christianity for a faith that empowers the individual to overcome the challenges of life (Maxwell 2006:205).

During the 2013 Annual Methodist Church in Zimbabwe Conference, the Presiding Bishop⁷ admitted the need for the church to move with time and understand the environment in which it is called to engage in ministry and mission (MCZ Minutes of Conference 2013:120). The Presiding Bishop (Rev Amos Ndhlumbi) argued that “there was need for MCZ to embrace contemporary methods of evangelism for its advantage in order to reach all age groups in the church” (:120). Ndhlumbi further argued that the church needs to question itself about its own church growth strategies and why they are not as effective as other younger ecclesial faith communities (:120). This missio-cultural examination of the healing ministry of MCZ within the Mabelreign, Epworth and Mbare (MEM) societies presents an empirical study that employed phenomenological method and interview research instruments to analyse the extent to which the church is responding to the healing needs of its members within the local cultural contexts of the selected societies.

have been used to refer to AICs are African Initiated/ Instituted Churches. However, for the sake of consistence, one term will be used.

⁷ The Presiding Bishop is the principal executive officer in the MCZ. He/she is also the one in charge with the pastoral and spiritual oversight of the whole church. This office represents the face of the (MCZ *Deed of Church Order and Standing Orders* 2007. 30(2), 31).

1.2 Location of the Study

The selected societies for this empirical study are in Harare, which is the capital city of Zimbabwe. The societies are a melting pot of migration from many parts of Zimbabwe and outside Zimbabwe to a lesser extent. The societies constitute the rich historical background of Methodism in Zimbabwe, from 1891 when British missionaries ‘planted’ the church among the local peoples (Gondongwe 2011:3; Mawire 2015:44).

1.2.1 Mabelreign

According to Baggs *et al* (2001:10), “Mabelreign is a middle class income suburb situated in the North-western side of Harare founded in 1892 by the missionaries”. Mandevere (2015:91) attests that “the suburb covers areas of Bluffhill, Sentosa, Greencroft, Cotswold Hills, Haig Park, Meyrick Park, St Andrews and Ashdon Park”. When the suburb was established, the missionaries built their church there, making Mabelreign to become a society for the whites⁸ only (Paradza 2016). From 1892, Mabelreign had been a white dominated suburb, until 1980 when Zimbabwe acquired independence. However as the capital city continued to grow, these whites moved to other suburbs like Mt Pleasant and Borrowdale and the middle class blacks occupied the Mabelreign area. Mabelreign Society is one of the few societies in the MCZ, together with Trinity, Mt Pleasant, Borrowdale, Greendale, Hillside and Aldersgate in Bulawayo, with both English and vernacular services. It is intrusive to note is that Mabelreign, in particular, no longer has any whites or ‘coloured’ ethnic groups who attend these English services. Most of the blacks who are members at Mabelreign society are local middle class Zimbabweans. Some people who regularly attend services at Mabelreign are people who have been in diaspora coming for the English services. Some local influential members of the society like the Former Zimbabwean Prime Minister, the late Morgan Tsvangirai was a members at Mabelreign. On the Eve of 2017 Christmas, President Emmerson Mnangagwa also visited Mabelreign church for the first time, probably not with the intention of being a member, but as a politician with probably to push his political agenda since he was campaigning for the 2018 presidential election. Mabelreign society is a hybrid in its ecclesial development and thus presents cultural differences. Therefore, the understanding of healing ministry within this society presents complexities. Since the Zimbabwean economy has been depressed for a long time, these

⁸Whites refer persons whose ethnicity is rooted in Euro-American identity.

members are also seeking healing solutions outside of the restricted environment of MCZ. Being African, these members have similar belief systems with fellow Africans that look to the ancestors for causes and meaning regarding acts of illness, misfortunes and death within family and community (Shoko 2007:59). This missio-cultural investigation will help find out how these members are dealing with their healing challenges.

1.2.2 Mbare

According to Makombe (2013: xviii) “Mbare was a Harare Municipal Township that was established in 1907 after some years of being referred to simply as the Salisbury Native Location. In 1946 the municipal township was renamed the Harare African Township” (Makombe 2013: xviii). However, in April 1982, the capital of the newly independent Zimbabwe – Salisbury – was renamed Harare and the Township was renamed after a local Shona chief Mbare (2013: xviii). Mbare area lies about five kilometres from the Central Business District of Harare. According to Makombe (2013:31), the people under chief Mbare lived in the space that covers the area from Musana and bordering with chief Chiremba, an area that became Epworth Mission. Baggs *et al* (2001:11) maintain that the process of low-income public housing provisions started in Mbare in 1897 when land was set aside for black workers. The missionaries established the first African Circuit for the natives in this African location, Mbare, while they established their membership in the places like Trinity and Mabelreign (Mujinga 2012:12).

The African location was a major source of accommodation for blacks until 1945 (Makombe 2013). “At the beginning of 1950, the location became the bachelor’s accommodation. Hostels with a four-bed space per room were constructed” (Baggs *et al* 2001:11). However, accommodation was finally overcrowded with a ratio of fifteen people to one room (Baggs *et al* 2001:15). After Zimbabwe attained independence, the hostels evolved family compounds. A number of Mbare society members come from these hostels, in most parts of Harare. “These hostels are home to many residents and are also one of the oldest urban residential settlements in the country” (Mabasa 2015). “The flats are known for their visibility dilapidated state, overcrowded houses and poor sanitation” (Baggs *et al* 2001:15). These flats are home to most members of Mbare Methodist Church.

Mbare area is argued to be the heart of Harare because of a number of reasons. First, “it is where the largest horticultural market in Zimbabwe is found that is called, ‘*Mbare Musika*’.

The *Musika* side is a busy market which sells mainly vegetables and other consumables. The place also attracts customers from all corners of the country due to the affordability of products especially agricultural products which are supplied in bulk by farmers. The place is also known for selling fresh agricultural products which come usually every morning from various farming areas of the country” (Madzima 2014).

Second, one of the famous football clubs, Dynamos, is nicknamed *DeMbare* because this is where they do their training session – in Rufaro Stadium, the second largest football ground in Zimbabwe. The third key activity that is associated with Mbare is the Mupedzanhamo “*end poverty*” flea market that provides space for hundreds of indigenous textile retailers and wholesalers to sell their products under one roof. According to Madzima (2014), “the place is known for providing locals with affordable second-hand clothes that are usually imported from Mozambique. The informal nature of the trading done at the place has earned it names such as ‘*Kotamai Boutique*’ (bend down boutique) in reference of the way people bend their bodies to choose the clothes of their choice” (Madzima 2014). The Methodist Church – Mbare society is demarcated by the durawall with Mupedzanhamo market. This has caused people to call the society Mbare Mupedzanhamo Methodist Church. “An estimated five thousand people are said to visit Mupedzanhamo daily” (Madzima 2014). Of significance to note is that a number of these people come from all over Harare and some have registered their membership with Mbare society probably because of its attractiveness.

The fourth geographical place is called *Siya-so* (leave it like that). According to Mandebvu, “*siya-so* area is the industrial hub of Mbare and is situated about four hundred metres east of the church. The market area-cum industry is made up of many indigenous traders and manufacturers of various products who also come from many parts of Harare” (2015). “Things like building material, car parts, farming equipment, household goods, and timber, to mention a few are sold there” (2015). The area has grown to be one of the biggest informal markets in Zimbabwe where customers are presented with a wide range of locally produced merchandises” (Mandebvu 2015). The informal traders come from most parts of Harare and a number of them have a membership at Mbare Methodist Church society. Given that Mbare accommodates a variety of people, as argued, it is evident that the understanding of healing ministry of this society is also diverse.

1.2.3 Epworth

Epworth is a peri-urban settlement about fifteen kilometres east of Harare (Masuku 2013). Gondongwe (2011:51) affirms that the settlement was established in the late 1890s by the Methodist missionaries. Gundani (2007:136) further argues that Epworth is the place where the missionaries were welcomed by the first African, Chief Chiremba. “Methodist Church acquired three farms in the area of Epworth, Glenwood and Adelaide” (Zimbabwe Homeless People Federation ZHPF 2009). Gundani (2007:151) insists that “by 1898, many of the residents of Epworth farm had converted to Methodist faith”. Gundani further stresses that “by the twentieth century, Epworth Mission became one of the few vibrant Christian settlements in Zimbabwe” (2007:151).

Throughout the colonial era, the settlement grew as a church mission (ZHPF 2009). In the late 1970s, the settlement saw a surge in the population as people fled the liberation warzones in which had made the countryside unsafe (2009). After the Zimbabwean independence of 1980, more people came to Harare in search of economic opportunities. Epworth, with its informal set up, provided a destination for the new arrivals (2009). The government decided that the MCZ should formalise the settlement rather than demolishing the houses. Faced with this unprecedented growth, MCZ donated part of the land to the government for subsequently establishing a local government structure (2009). In 1986, the Local Board was entered to formalize the settlement and this attracted more people to go to Epworth to seek accommodation. The influx was also necessitated by the rising cost of living, to the extent that even the middle class citizens from medium densities like Braeside and Queensdale retreated into the slum areas of Epworth in search of a cheaper life (Masuku 2013; ZHPF 2009). This situation resulted in the emergence of more informal settlements as people occupied the remaining spaces, giving birth to new settlements called ‘*magada*’ (unplanned settlements) (ZHPF 2009). A number of these people are members at Epworth society.

According to ZHPF, this situation led to more than seventy percent of the thirty thousand families in Epworth to stay in informal settlements (2009). Msindo, Gutsa and Chiguya (2013) argue that “some of the people who found refuge in Epworth were the victims of the Zimbabwe’s clean-up campaign of 2005, which is popularly known as Operation *Murambatsvina*”. The situation was so bad that some of the informal houses were destroyed by rain because they were poorly built (Chiripasi 2015). Msindo *et al* (2013) confirmed that

“most of the people in Epworth are poor. This style of life is different from that of the people Mabelreign as noted earlier”. Sigauke (2002) argues that “most of the people especially those in the informal settlement build their houses with poles, dagga, sunburnt earth bricks, wooden planks, grass and plastics. The major reasons that prompted to people migrate to Epworth informal settlement includes: expensive residential locations, family expansion and cost of rentals in the formal suburbs” (Sigauke 2002). This coming together of the people from the margins brings a cultural hybrid and diverse people with different healing needs.

Moreover, “some Zimbabweans go to settle in Epworth with the intention of owning a property nearer to Harare” (Sigauke 2002). In addition, “politician’s use the unsettled areas as an agenda item in their political campaigns to advocate for land justice for those that are landless and live on the margins of mainstream society” (Msindo *et al* 2013). Given the high population of people now residing in Epworth, Methodism is no longer easy to define. MCZ has lost control of the spiritual activities of the mission to the secular authorities. People who came to settle in Epworth brought their diverse faiths. This religious intercourse has transformed Epworth into a multi-faith community. Some members of the Methodist church opt to go to ‘other churches’ in search of more religio-cultural responsive healing. It is this phenomenon that has influenced the motivation of this missio-cultural study. The objective is to examine ways in which Epworth Methodist society is responding to the healing needs of its members. The three societies identified for this qualitative study are facing contemporary challenges linked to the healing needs of their members.

1.3 Motivation

This missio-cultural research was motivated by three challenges which influenced my interest in this subject, namely: contextual pastoral challenges, the academic challenges, and missiological challenges within the MCZ.

1.3.1 Contextual Pastoral Challenges

My experience as a Methodist minister has exposed me to the challenges that members and clergy encounter when members fail to attend church worship because family members have become sick. “Some of the members visit traditional healers, African Initiated Churches and other churches that are described as belonging to the Pentecostal and ‘Charismatic

movements' like United Family International Church (UFIC) and Prophetic Healing and Deliverance Ministry (PHD) to seek healing remedies for their personal illness or for a family member" (Vengeyi 2011; Chitando *et al* 2013). One of the reasons for this migration is the quest for healing and deliverance ministry, which, they feel, is not effectively embraced and expressed within the MCZ. It could therefore be argued that some MCZ members find it difficult to reconcile their sense of belonging to their African traditional cultural heritage with the Western bequeathed form of Christianity as presented by their local church.

According to Chitando and Klagba (2013:2), "healing is a broad concept that refers to the restoration of health in every area of life, mentally, physically, emotionally, socially and spiritually". However, this understanding was betrayed by the socio-political situation of Zimbabwe in the first decade of the twenty first century. Hanke argues that "by the end of November 2008, the Zimbabwean dollar 'died' from hyperinflation⁹ that made it useless" (2009). Hanke further argues that,

Foreign currencies replaced the Zimbabwean dollar in a rapid and spontaneous manner. This 'dollarization' process made the Zimbabwe paper money remnant to circulate alongside foreign currencies, its real value against the United States dollar was cut in half every two days (Hanke 2009).

This hyperinflation created a big challenge for the health sector throughout the nation. The MCZ members in MEM, like other Zimbabweans, had to deal with their health challenges and many looked to the church as the possible solution for their healing needs.

Parusigere observes that, "since 1990, 3 million Zimbabweans migrated to South Africa mainly because of the socio-political crisis. By November 2008, the Zimbabwean annual inflation rate was 89.7 sextillion" (2008). McGreal (2008) further states "that eighty percent of Zimbabwe's population was living on less than £1 a day and nearly half, chronically malnourished. The Reserve Bank resorted to strapping zeros but by September 2008, inflation had reached quindecillion and novemdecillion percent". This period saw most Zimbabweans seeking healing solutions more than ever before. The Zimbabwean socio-economic crisis did not change even after the introduction of the multicurrency regime. The

⁹ According to Webster New Encyclopedic Dictionary, hyperinflation is whereby inflation becomes very high in a very short space of time (1995:488).

deteriorated socio-economic conditions did not spare Methodist members of the selected societies.

Chirongoma (2006:175) argues that healthcare is one of the important social concerns and needs of the Zimbabwean people. The Zimbabwean health system used to compare favourably with most other countries in Sub-Saharan Africa. Mangena and Mandizha bemoan that “this deteriorated health-care situation in Zimbabwe was characterized by shortage of key medical staff such as doctors, nurses and other healthcare professionals” (2013:133). Such conditions and all others services including healthcare deteriorated and the life expectancy fell from sixty-five years to forty-three years in 2005 (2013). In demonstrating the seriousness of health challenges in Zimbabwe, Mangena and Mandizha (2013), contend that “in 2009, it was estimated that sixty-nine percent of doctors and eighty percent of posts for midwives were vacant” (2013). In analysing this situation, Chitando concludes that this milieu caused a lot of despair and depression among the citizens (2009:29). This situation was worse in MCZ because they had neither a competitive health-care institution to respond to the needs of the people nor any other solution for its sick members except the church’s policy book, namely, *Deed of Church and Standing Orders*. The MCU Constitution is silent on the subject of healing ministry within the church and could not therefore offer intentional guidelines.

The socio-economic and political crisis of this period created an obsession with healing as the new way of accessing individual wellbeing within the public discourse because of the absence or weakening of the community and family support systems that were severely compromised. The ministry and mission of the churches in Zimbabwe were also compromised because the members of the churches were also heavily affected by hyperinflation. According to Mangena and Mandizha (2013:134), “Zimbabweans are generally a very religious people and they found Pentecostal spirituality very attractive”. Zimunya and Gwara maintain that “in such a scenario of poverty and uncertain events, Pentecostal Churches emerged and offered a much needed relief on the healing of all ailments” (2013:190). This situation saw Methodist members practicing dual membership or completely transferring their membership to the new churches (See also Mukonyora 2007).

1.3.2 Academic Motivation

This study was also motivated by an academic research gap that was identified during my honours degree research on the topic: *A comparative analysis of the healing miracles of Jesus and those of the African Apostolic Church of Johane Marange* (Mujinga 2009). In this research I observed that the contemporary era in Zimbabwe is characterized by a significant movement of members away from the mainline churches¹⁰ to the African Initiated Churches (AICs). One of the pulling factors identified in the research was the members' need for a culturally sensitive and "effective healing ministry" (Mujinga 2009:2) (See also Asamoah-Gyadu 2010:2; Maxwell 2006:195). This need has resulted in some members of the mainline churches worshipping at their home congregations by day and then proceeding to AIC healing worship by night (Anderson 2007:213). Tutu describes this situation as "religious schizophrenia" (1997:47). This migration of the MCZ members to AICs in search of their healing ministry is a pointer to people's perceptions about pneumatological presence or absence of this phenomenon within the traditional missionary ecclesiological identity and vocation of MCZ. The study confirmed that some members completely transferred their membership allegiance to the AIC faith communities in order to continue receiving the benefits of their brand of healing ministry (Mujinga 2009:47). Since some members of the MCZ are also involved in seeking healing from other faith communities, it calls into question why they are not finding the healing ministry that is present in their own local church meaningful and effective. This phenomenon therefore called for an in-depth study of the healing ministry in MCZ.

The second academic motivation was linked to the absence of critical studies of this phenomenon by Methodist scholars from the local context. Shoko confirms that "in Zimbabwe, healing ministry within mainline churches has not received much academic research attention from scholars" (2003:208). The materials available are produced by scholars writing about healing in the MCZ from a historical perspective (Thorpe 1951;

¹⁰ According to de Gruchy (2014:15-17): "the word mainline is part of the worldwide confessional families whether Anglican, Lutheran, Baptist, Reformed and Methodist. This is the identity they have inherited, an identity with a range of distinctive features, which are both local and global. The churches share the origins, history, faith, spirituality and practice whether ethical or liturgical with global partners. These churches have been referred to, inter alia as settler, colonial, mission, multiracial and the ecumenical churches. 'Settler' referring to their planting as a result of European immigration; 'colonial' refers to their relationship to the colonial enterprise and to the colonial authorities with whom they generally had a cosy relationship; 'mission' refers to the fact that each of them began extensive mission programmes among indigenous people to such an extent that they have become black majority churches."

Zvobgo 1991, 1996; Linden and Weller 1984; Gondongwe 2011; Makoti 2012; Mawire 2015). According to Gondongwe (2011:63), “one way in which the church exercised its ministry was by engaging in healing ministry”. However, Gondongwe’s definition of healing ministry was related to the history of medical clinics and hospitals in Zimbabwe since 1913-1964. The Euro-centric understanding of healing written by some of these scholars did not answer the definition of healing in terms of the one that takes place through pastoral care, fellowship, sacraments, medical practices, prayer, exorcism and counselling that is practised by the MCZ (See also Dickinson 1995:175; Anderson 2007:37; MacNutt 1988:162; Hughes 2007:5). Most of the writings in the MCZ present the perspective of healing ministry from a Euro-centric missionary heritage rather than from a local missio-cultural critique. This research is therefore aimed at examining the healing ministry of the MCZ through the expressions of selective local societies.

The second category of materials on the healing ministry within the Zimbabwean context comes from the non-religious scholars. These scholars are divided into pre- and post-twentieth century. According to Shoko (2007:208), “the pre-twentieth century scholars were mainly scholars of sociology, medicine and missiology who focused on the three care systems – traditional medicine (Chavhunduka 1978), modern medical praxis (Gelfand 1971) and the faith healing material in AICs” (Daneel 1974). All of these studies assessed the material in relation to the Shona sociocultural and religious systems and have resulted in the reappraisal of traditional medicine by calling for the integration of traditional and Western medicine. Zvobgo confirms that, although missionaries contributed much to education, Zimbabwean scholarship did not do justice to their contribution to healthcare ministry (Zvobgo 1986:113).

Post-twentieth century scholars have addressed two areas related to healing ministry in the Zimbabwean context. The first relates to the younger spirited charismatic/Pentecostal and AICs that are more open to contextualizing healing rituals. In this category, we find scholars like Mukonyora (2007), Shoko (2003a; 2003b; 2007), Mapuranga (2006), Togarasei (2009), Maxwell (2006), Biri (2012), and Mapuranga, Chitando and Gunda (2013). Although these researchers focused on healing, none of them has dealt with the missio-cultural challenge faced by the MCZ. It is this gap that this study seeks to address.

The second group of post-twentieth century scholars grappled with healing in the face of HIV and AIDS. One of the prominent scholars is Ezra Chitando who has written widely and

also co-authored with other local, regional and international scholars (Chitando 2003, 2007, 2009, 2012). These groups of scholars also have not critically engaged with the missio-cultural healing challenges faced by the mainline churches especially the MCZ. This study therefore gives attention to the three selected societies of MCZ to examine the missio-cultural challenges encountered by members in their response to the church's healing ministry.

1.3.3 Missional Motivation

This empirical study seeks to examine how the missional identity, vocation and witness of the three societies within the MCZ converse with the local culture and give expression to its healing ministry. According to Kirk (2000:25), "mission is central to the purpose and activities of God in and for the whole universe" (see also Verstraelen 1995:447). Bosch (1991:3) argues that Christian mission is the total task of which God has sent the church for salvation of the world. Therefore in the missional identity and witness of the MCZ that constitutes a part of Jesus' on-going life-giving mission, commitment to the ministry of healing is indispensable. This call to participate in the *missio Dei* (God's mission) means sharing the good news with all people, especially those that are on the margins of society (Bevans and Schroeder 2004; Bosch 1991:10; Richardson and Bowen 1983:373; Iyakaremye 2013:64).

MCZ is called to fulfil this mission in a given cultural context. Therefore, missio-cultural theory of engaging with the healing ministry phenomenon becomes the theoretical framework of this study. This framework was identified in view of the claim that "the missionaries did not adequately understand the African society that they came to evangelize". Muzorewa (2000:32) argues that "European missionaries emphasized the discontinuity between Christianity and African culture to such an extent that they excluded aspects of continuity between Christianity and African customs and religion. Christianity was heavily influenced by westernization" (Bediako 1997:3). "Missionaries condemned local practices without proper evaluation of African religious beliefs and practices and authenticated them with their cultural and religious practices" (Parratt 1997:4). Bediako (1999:268) also maintained that "due to the impact of Western missions and the long history of western cultural dominance, western forms of Christianity have traditionally exercised a strong influence to churches across the world".

MCZ is one of the churches of the British missionary heritage in Zimbabwe (Zvobgo 1991:2). An analysis of this discontinuity leaves more to be desired. Using the words of Verkuyl (1975:4), *missio-hominum* (mission of humanity) is not *missio-ecclesiarum* (mission of the church). The missionaries emphasised their individuality, leaving both *missio-Dei* (mission of God) and *missio-ecclesiarum* in their missionary enterprise in Zimbabwe. The missional vitality of MCZ seems to be more committed to a Euro-centric understanding and practice of the Christian faith than the risk of conversing and learn from the local culture in demonstrating the efficacy of the gospel that it proclaims. This missio-cultural disconnect of the MCZ seems to be affecting the effectiveness of its healing ministry within the local culture.

1.4 Problem and Research Question

The key research question of this study is: “in what ways does MCZ participate in God’s mission within the context of diverse cultural understanding of healing in MEM societies?

1.4.1 Research Sub-Questions

- i. How does the missional identity and vocation of MCZ relates to healing ministry?
- ii. How should the socio-cultural factors in the selected societies of MCZ inform their healing ministries?
- iii. How has the healing ministry evolved within the MCZ?
- iv. What would be the possible missio-cultural strategies that MCZ could employ to address the challenges posed by competing healing practices?

1.4.2 Objectives

- i. To identify the missional identity and vocation of MCZ as it relates to healing ministry.
- ii. To examine the socio-cultural factors in the selected societies of MCZ that should inform their healing ministries.
- iii. To explore how the healing ministry evolved within the MCZ.
- iv. To investigate the possible missio-cultural strategies MCZ could employ to address the challenges posed by competing healing practices.

1.5 Brief Methodology

Although the methodology will be discussed in detail in Chapter Seven, it is important to note that any research that lacks the methodology create some challenges in scholarship. The research has used both primary and secondary data. The secondary data was sourced from both libraries and online academic search engines such Google Scholar, Ebscohost, Research Space, Peer Reviewed Journals, and other Databases on CD-ROM. Articles and other relevant books, journals, and theses were hand-searched for this missio-cultural examination of the healing ministry within MEM of the MCZ. The primary sources in this missio-cultural study were interviews using semi-structured, structured and focus group interviews (see chapter 7). Special consideration was given to materials under arts, humanities and social sciences (Mouton, 2009:206). The research also benefited from the missio-cultural conceptual framework that and inculturation to respond to the research question.

1.6 Theoretical Framework

1.6.1 Missio-Cultural Conceptual Framework

The theoretical framework that was posited for this study embraces an interdisciplinary approach on the issues about God's mission (*missio Dei*) through the mission of the church (*missio ecclesia*) and culture. In this research, interdisciplinary approach refers to the coming together of missional and cultural disciplines. This coming together is what forms the theoretical conceptual theory known as missio-cultural. The leading scholars in this debate is study Hewitt (2012). Others scholars like Bosch (1991); Verkuyl (1975); Kirk 2000 and Musasiwa 2002. The first task in discussing the missio-cultural theoretical framework is to explore the two terms, mission and culture, independent of the other. The establishment of mission stations by the missionaries will also be discussed with the aim of identifying how these centres were meant to demean the African culture as spiritually evil and uncivilized thereby embracing the Euro-centric missionary cultures as spiritually life giving and humanely civilizing (Mujinga 2017:119-120). According to Hewitt when religion and local cultures are not at home with each other and tend to produce hatred instead of love and peace in the society. When the Christian faith is treated as a foreign commodity, it becomes a curse instead of a blessing to the people; this is the point at which religion fails people and ends up destroying lives and property. An inculturation of the Christian message

creates an awareness that God loves all people and that Christianity has not come to divide them (2012).

1.6.1.1 Mission

According to Bosch “mission is God’s turning to the world in respect of creation, care, redemption and consummation” (1991:391). Musasiwa (2002:256) adds that “mission is God giving up himself, his becoming man, his laying aside of his divine prerogatives and taking our humanity, his moving into the world, in his Son and Spirit”. Verkuyl adds that “mission is God the Father sending the Son, and the Son is both the Sent One and the Sender” (1975:3). “The Father together with the Son, send the Holy Spirit who in turn sends the church, congregations, apostles and servants laying them under obligation in discharging his work” (Musasiwa 2002:256). If mission belongs to God, then God is the owner of the mission (*mission Dei*). The phrase *missio-Dei*, as observed by Verstraelen (1995:447), “gained general currency in 1952 at the Willingen World Mission Conference. The conference agreed that mission work is God’s own work. God the Creator of all things submerged in his own world as a stranger, as a displaced person, an outcast, in solidarity with other outcasts and strangers who in the world pursues a very special hidden road in order to liberate it” (1995:448). In Luther’s theology, mission is always pre-eminently the work of the triune God - *missio Dei* - and its goal and outcome is the coming of the kingdom of God (Engelsvike 2009:431). Luther sees the church, along with God’s word and every baptized believer, as crucial divine instruments for mission (2009:431). Musasiwa adds that “God is a missionary God, a God who crosses frontiers towards the world” (2002:265). These frontiers, according to Neill, Anderson and Goodwin, are not only geographical, “but they are also ideological, religious, cultural, social, economic and racial” (1970:387). The mission of God as transported and transplanted by the Methodists missionaries in Zimbabwe redefined the understanding and practice of healing among the locals according to the mandate of their mission that was determined in England rather than in Zimbabwe. However, the post-colonial MCZ also found itself grappling with the definition of healing ministry in the face of socio-political realities of postcoloniality.

Kirk argues that “God’s mission embraces both the church and the world and it is the church’s privilege to participate in God’s mission” (2000:25). This *missio-cultural* study that employs a phenomenological method of enquiry will examine how the MCZ mission

engages and converses with the culture through the expression of the healing ministry of the selected societies of MCZ. According to Ezekiel (2011:5), “mission is oriented to the Kingdom of God”. The question that begs for an answer in this research is how the MCZ engages in God’s mission through the diverse cultural understanding of healing in MEM societies.

Bosch (1991:3) further argues “that Christian mission is the total task of which God has sent the church for salvation of the world”. Therefore, in the missional identity and witness of the MCZ that constitutes a part of Jesus’ on-going life-giving mission, commitment to the ministry of healing is indispensable. This call to participate in the *missio Dei* means sharing the good news with all people, especially those that are on the margins of society (see also Bevans and Schroeder 2004; Bosch 1991:10; Richardson and Bowen 1983:373). Ezekiel concludes that “*missio-Dei* and *missio-ecclesiae* are inseparable. The former energises the latter and the latter realises the former” (2011:6). This research argues that if the missional objective of MCZ is to give life to its members, then it must effectively deal with their quest for healing in the cultural environment of MEM societies.

1.6.1.2 The Establishment of Mission Stations in Zimbabwe

The concept of mission is also used in selective ways to refer to the location or a dwelling place that was established by the missionaries (mission station), secluded from the rest of the community as a sanctuary or centre of proselytization, and second, as God’s act of sending out (Hewitt 2012). According to Richardson and Bowen, mission is also used conceptually to refer to the ecclesial community’s attempt to get human beings to separate themselves from a deprived and sinful world by relocating them into a totally spiritual transformation within the church (centre) or to absorb church, its faith, its message into the total secular transformation of the world (sent out) (1983:373). Related to this understanding of mission is the notion that mission embodies God’s liberating presence in every human situation (Duncan 2003:5). Duncan further acknowledges that;

When missionaries came to Africa they established mission stations¹¹ as a place for the orphans, the aged, the disabled and those accused of witchcraft that sought refuge. The mission station also accommodated girls seeking to escape being

¹¹ MCZ has seven mission stations which all now have Methodist High schools namely, Chemhanza, Kwenda, Marshal Hartley, Waddilove, Pakame, Chivero and Thekwane (Zvobgo 1991; Banana 1991; Gondongwe 2011).

married to older men chosen by their parents and the widows seeking to avoid the cultural obligation to marry the deceased husband's brother (2003:5).

From a missionary point of view, mission stations were havens of refuge for the victims of heathen superstitions and oppression from the traditional African point of view (2003:18). Banana contends that Methodist mission stations existed to serve as settlements of Christian's example to the rest of the pagan world (1991:66). However, mission stations were also centres of immorality and safe havens for dissolute criminals (Duncan 2003:18; see also Murove 2011:31). This statement suggests that those who were classified as so-called 'black sheep' of the society (unwanted/rejected) found acceptance in the mission centres (Mujinga 2017:119). Those who had no apparent motive separating themselves from the community to join a mission station were classified as insane in the eyes of the locals (Duncan 2003:18). Mission stations were also means by which Africans came under the influence of Euro-centric missionary Christianity (2003:19). What we can conclude from the points raised by Duncan is that the missionaries were gate-keepers at the borders between traditional African culture and religion and European Christianity and all its trappings, and the quality of their response and engagement determined to some extent the level of inculturation of the gospel within the local context (2003:61).

Mission is God's task for the church for the salvation of the world (1991:3). Within the African context, mission stations engaged in evangelization strategies of witnessing, proclamation, teaching and celebration of sacraments and public education that transformed many lives (2005:464). Life in the mission station was structured to achieve ideological transformation. The conversion to Christianity involved cultural dislocation from the past tribal practices and a complete break from the traditions of the past life (2003:19, 21). This included a shift from the African cultural methods of healing to embrace the western medical approach. For Duncan, this type of life came easily for those who had endured disruption already in their lives (2003:23). Missionaries were skilled at identifying groups that experienced a variety of adverse circumstances and were ripe for conversion. They were also skilled in the process of resocialization of prospective converts who were removed from their community and given shelter within the mission complex. The mission stations usually included a school, a hospital and an orphanage and all members received intensive re-education (2003:51). The mission station therefore occupied a critical space in the colonial encounter of Africans and their intellectual experiences of colonial expansion (2003:51). The mission stations also served as centres of de-culturizing Africans and ensuring the

dominance of the Euro-centric missionary culture within the local context (Mujinga 2017:119). The process of inculturation therefore involved forces of hybridity and contradiction in determining the quality of engagement between mission and culture (Hewitt 2012).

1.6.1.3 Culture

According to Hewitt, the term culture has many meanings and dimensions, and there is no one definition that is agreed by scholars because they differ in their understanding of the subject (2012:10). Although definitions are contested, however, a selected few are worth pursuing in this missio-cultural study of the healing ministry within MEM in order to come out with a working definition. Oduyoye and Vroom defines culture as,

A way of being and thinking including the activities, attitudes and world views that people constitute, the difference that exists between one people and another. Culture is gathered and carried in language, symbols, and rituals. It gives expression to and is expressed in religious belief (2003:45).

Muller *et al* argue that culture refers to the activity through which men and women influence the environment in which they live, with their physical and spiritual powers partially changing it, but at the same time developing themselves as individuals and members of the community (2006:94; Hewitt 2012:10). From these definitions, it could be argued that the missionaries and the local Africans engaged in a cultural divergence.

Luzbetak maintains that the early definitions of culture embrace a theological base and model that are deemed to be useful, open, fitting and stimulating (1996:134). According to Nangoli, “culture denotes the language people speak, how they behave, live, relate to one another, dress, worship their God, take care of their own, marry for reproductive purposes, name and baptise their children, care for the elderly, bury their dead and generally anything that distinguishes them from other people of the world” (1986:54). However, Kanyoro (2002:13-14) posits “that religion and culture cannot be separated because culture and religion express themselves through each other”. Schreiter identifies culture as “the creed of the community identity” (2015:13). Within the African context, culture and religion embrace and inform each other in all areas of life. According to Schreiter, culture is not static; therefore culture and religion within the contemporary African context, while they are indelibly linked to the past happenings of a people, have also mutated and adapted to be

relevant to the present realities and challenges of life (2015:13). In this missio-cultural study, one notes that when the European missionaries came to Zimbabwe, they attempted to separate culture and religion, which proved impossible.

In view of the contributions made by Nangoli, Sinnreich, Schreiter and Mapuranga, this missio-cultural research appreciates that when the missionaries came with the gospel to Zimbabwe, the natives had their own culture and religion. They had their understanding of God and healing from their own cultural perspective. As such, these MCZ societies are now using the post-colonial lenses to rediscover and appropriate the deep meanings and systems of their culture in order to have a relevant religion that answers to their healing needs. In view of this, Lartey, Nwachuku and wa Kasongo maintain that Africans live their spirituality through the totality of their culture and organize their health system in the context of their worldview (1994:18). This understanding of African culture as a means to define health becomes the premises for this study. Kirk emphasised that “culture is a comprehensive plan for living and a society’s complex, integrated coping mechanism (2000:8)

Colonial powers made the most serious mistake by underestimating the cultural strength of the African people. Frances Davison of Matopo mission in 1915 stressed that “within the native, sickness among the Africans is always the result of witchcraft or the influence of their ancestral spirits...if one can show them that this is not true he is doing much to overthrow some of their superstitions” (1996:204). By ministering to the physical suffering of the people, the missionaries paved the way for ministering to their spiritual needs. He who neglects this part of the work makes a grave mistake.

The culture which was misunderstood by missionaries who made the missional enterprise of the MCZ, led them to have challenges with the (Dickson 1984:117; 2002:114; Bediako 2000: xi). Bowen also observed that “when different cultures meet there is conflict, coexistence, competition or cross fertilization” (1998:82). However, the coming of missionaries had conflict with the African culture. Kurewa points out that “as cultural awareness increased in Africa, the Christian gospel and its cultural identity in Sub-Saharan Africa should be critically examined by the African Church” (2000:12). In view of this, Kurewa further states that the missionaries used Western culture and Western practices that they knew best to propagate the gospel (Kurewa 2000:10).

According to Hewitt “as countries emerged from the shadows of colonialism, especially in Asia and Africa, the churches founded by Western missionaries began to search for ways to their foreignness and to take a firmer root in the local soil into which they had been planted. This process is called indigenization” (2012:7). Bonsu defines the concept of indigenization “as an attempt to express the Christian message in the categories of thought of the native or the insider” (2005:15). Kanyoro states that “African Christian faith is dualistic with one foot in African religion and culture and another in the church and western culture” (2002:13). Within the selected societies of MCZ that are identified, they possessed the inherent contradiction between European culture and African culture. Hewitt is therefore correct to bring together mission and culture, embodied within the concept of missio-cultural that constitutes the theoretical frame of this study (2012). This research has therefore adopted Hewitt’s combination of mission and culture to form a missio-cultural framework to examine the extent to which MCZ is responding to the healing needs of their members in MEM in post-colonial Zimbabwe. It is understood that mission centres functioned as anchorages of missionary cultures rather than embracing and conversing in an open and positive way with African culture.

1.6.1.4 Mission-cultural Conceptual Framework

To understand the interplay between mission and culture in the selected societies of MCZ, the missio-cultural framework proposed by Roderick Hewitt (2012) was adopted. The justification for using Hewitt’s missio-cultural theoretical framework is because it was utilised to interrogate the dynamics between mission and culture in Jamaica, a global South country like Zimbabwe. However within the Zimbabwean context the missio-cultural conceptual framework is utilised in a limited way to interrogate its influences upon the understanding and practice of the healing ministry within the selective MCZ societies. As argued earlier, these societies represents the quest for healing that this research has interests in. According to Evans, “the combination of mission and culture brings together a missio-cultural perspective that speaks of the interface of God’s ongoing action in the world with human accountabilities and contexts of specific responses” (Hewitt 2012: xxviii). Hewitt adds that “the missio-cultural nexus of any study embraces an understanding of mission as a relational initiative that begins with God” (Hewitt 2012: xxviii). Bosch (1991:3) argues further that “the mission of God is missio-*Dei* and it states that God is God for people” (See also Musasiwa 2002:256ff). “The involvement and nature of God in mission embraces both

the ecclesia and nature of the church's honour to take part through in the Great Commission" (Kirk 2000:25). Mission refers to the proclamation of the Gospel among people in a given cultural milieu.

The relationship between the MCZ's mission and the cultural influence on the healing ministry phenomenon was drawn into dialogue with the aim of finding out the responses of MCZ to its members' quest for healing commodity. Kirk defines a dialogue as a means of building relationships of trust between those of different convictions and helping to understand others' point of view (2006:21). The missio-cultural dialogue therefore brings mission and culture together (Kirk 2000:25; Verstraelen 1995:447). However, it is not easy for the missionaries to amalgamate mission and culture together because they misunderstood their culture to be the culture of God and therefore was supposed to define African culture. Bosch, states that Christian mission is the total task where God sent the church for the salvation of the world (Bosch 1991:3). Therefore, if the missional identity and witness of the MCZ constitutes a part of Jesus' on-going life-giving mission, then commitment to the ministry of healing is indispensable. The call of the church to participate in the *missio Dei* means sharing the good news with all people, especially those on the margins of the society (Bevans and Schroeder 2004; Bosch 1991:10; Richardson and Bowen 1983:373; Iyakaremye 2013:64). This research argues that if the missional objective of MCZ is to give life to its members, then it must effectively deal with their quest for healing in the cultural environment of MEM societies. Therefore the missio-cultural conceptual framework of this study is employed as a dialoguing space between mission and culture in the understanding of healing ministry in MEM societies of the MCZ. The limitation of this theoretical framework is that it is relatively new and it is its first time to be tested in the research from the global south. This study shows that the framework's struggle to overcome the dichotomy between God's mission and culture, makes it a viable to analyse MCZ healing ministry in Zimbabwean context where most people did not distinguish between religion and culture. However, to ensure its contextuality, the study amplified the theoretical framework with inculturative imagination.

1.7 Inculturation

The study employed inculturative imagination¹² as proposed by Edward Antonio (2006) in conversation with the missio-cultural theoretical framework in order to examine how MEM societies respond meaningfully to the healing needs of their members. According to Antonio, “definitions are dangerous things for they always purport to offer more than they can actually deliver. They can offer too much or too little. They can pretend to universality they do not possess or they can be overly realistic” (2006:29). Antonio further argues that there is no such thing as inculturation in the abstract since to inculturate necessarily means to attend to the structures of meaning and to the form and content of ritual practice in a certain culture (2006:29).

Many theologians have grappled with the definition of inculturation, but more often, the term is defined from their given context, theological perspective or cultural backgrounds. Such a situation has brought diverse definitions of inculturation, which are grounded in a given situation (Antonio 2006:29). In response to these diverse and at times conflicting understandings of inculturation, Antonio argues that,

Inculturation is a situated discourse about situated-ness of all human practices, meaning that there can be no definition of inculturation which is qualifiedly universal and applicable to all situations because inculturation in Africa is not a monolithic practice...there are varieties of inculturation as practiced by congregants. Therefore, there is no purely agreeable definition of inculturation but rather a working definition (2006:29).

¹² I am aware that the word inculturation is a development of other terms that were used by African theologians to make the gospel of Christ feel at home in Africa. Such terms were applied spontaneously during the research process but inculturation will be mostly used. Such words that overlap with inculturation are “adaptation which implied the selection of certain rites and customs, purifying them and asserting them within Christian rituals where there were some apparent similarities” (Waliggo 1986:11). “The other word used together with adaptation is accommodation fitting all the elements of the Christian life, pastoral, rituals, didactic and spiritual into the customs of the faithful being evangelized” (Waliggo 1986:11). Enculturation is the process by which an individual acquires a mental representation of beliefs, knowledge and patterns of behaviour that requires this person to function as a member of a culture (Antonio 2006:30; see also Shorter 1988:5). Acculturation is the contact or encounter between two cultures and the changes that result (Bonsu 2005:19). Interculturation means that the process of inculturation must be lived in partnership and mutuality (Shorter 2006:14). Incarnation means that Christ himself chose to become man in order to save humanity. Christ had no alternative, but to do the same in every culture and time in order to bring salvation (Waliggo 1986:11). Localization is the using of meaningful rituals and symbols in African culture to speak to the people of today (Mpigi 2002:126; Bonsu 2005:15). Contextualization is relating the gospel to the cultural context (Hewitt 2012:15). Africanization was a thorough decisive Africanization of leadership (Mpigi 2002:117). The last word is skenosis proposed by Pobee in place of inculturation and contextualization and other terms used to describe the gospel-culture relationship. Skenosis means to dwell, pitch one’s tent, or the tabernacling of the soul of the eternal and non-negotiable gospel of Christ (Pobee 1992:23-41).

In order to appreciate the complex definitions of inculturation as claimed by Antonio, the research will present how the concept has evolved and the working definition that is utilised within this missio-cultural research on the healing ministry within the selected societies of MCZ. One of the important reasons for using an inculturation lens in this study is influenced by the need to respond to the question raised by Kurewa, that “if the missionaries used their culture to propagate the gospel in Africa, what is preventing the African church today from using its own cultures to communicate the same gospel even more effectively?” (2000:12).

The concept of inculturation emerged out of Roman Catholic theological reflections. According to Bonsu (2005:19), the word inculturation was first used by a Gregorian University Professor, Father Joseph Masson in Rome on the eve of the Second Vatican Council in 1962. Father Pedro Arrupe popularized the word in 1978 (:19; Magesa 2004:51). Fr Arrupe argues that “inculturation is the integration of the Christian experience of a local church into a culture of its people, in such a way that this experience not only is expressed within the host culture to create a new identity and communion with the culture but also to the enrichment of the church globally” (Bonsu 2005:19). Shorter further defines inculturation as “a continuous dialogue of faith and culture or cultures” (2006:11).

Pope John Paul II describes inculturation as “the intimate transformation of authentic cultural values through their integration in Christianity and the intersection of Christianity in the various human cultures” (Shorter 2006:3). The word was used to replace terms such as indigenization, accommodation, adaptation, acculturation, enculturation and incarnation as argued earlier (see Shorter 2006:3; Barfield 1997; Owoahen-Acheampong 1998:29). According to Hewitt, inculturation and contextualization in missiological studies means almost the same in describing how the Christian message takes root within the language of a people (2012:xxix). Ukpong states that “inculturation is a way of doing theology that endeavours to interpret Christian faith from the perspective of the social cultural context and historical experiences of different people” (1984:30). Since inculturation will be used as an associate and accompanying lens of missio-cultural conceptual framework to help identify the common ground of dialogue between the healing mission of MCZ in the selected societies and their cultural understanding of healing, inculturation invites the mission and culture to a round table for mutual understanding where mission will speak with the cultural language of MEM societies of the MCZ.

Inculturation gained more ground in recent studies because of its reciprocal and critical interaction between the Christian faith and culture in a historical process (Shorter 2006:13 see also Hewitt 2012:17). Magesa (1994: 132) points out that inculturation designates the way Christianity is expressed in Africa and it explains how the Gospel interfaces with the local culture. In this empirical missio-cultural research, inculturation describes the ways in which the African world is modified and transformed through reciprocal interaction with the gospel that was transported and transplanted by western missionaries (see also Mutambara 2006; Bowie 2001; Bate 1999; Shorter 2006; Arbuckle 2010).

Oduyoye and Vroom (2003:45) argue that “inculturation is the way in which the gospel is applied into and lived experiences of people within Africa”. The inculturation lens of this study examines the ways in which the MCZ through the selected societies have acted to inculturate the gospel, to fit into the meaning and systems of local people’s quest for fullness of life. This missio-cultural investigation seeks to identify those signposts that points to culturally meaningful ways that the church’s mission, through the communication of the gospel, can more effectively respond to the healing needs of local people. Inculturation therefore becomes a process whereby faith that is already embodied in one culture encounters another culture through genuine reciprocal relationship (Owoahene-Acheampong 1998:5). In this encounter, faith becomes part and parcel of this new culture (Ukpong 1984:30). In his contribution, Ukpong stresses that in the inculturation process, the theologian’s task consists of rethinking and reshaping the original Christian message into an African cultural environment (1984:30). This is the missional task of MCZ in MEM societies. Owoahene-Acheampong (1998:6) maintains that “there has always been a complaint in the missionary churches about the kind of Christianity that was brought to them by missionaries and colonial administrators”. The inculturation process therefore seeks to make the Christian message more meaningful, appropriate and relevant to the meaning and systems of a given cultural environment.

Bate (1999:258) stresses that “the process of inculturation was initially linked to the attempt to make the church become part of the culture of the people”. The Methodist mission in Africa seemed to remain like a plant that stayed in the flowerpot and therefore maintained shallow roots when it came into the African soil. The Euro-centric Christianity did not take genuine steps to understand the African way of life but rather created a dependency syndrome that made Africans embrace the church in order to benefit from the missionary

medical donations (see Zvobgo 1991; Gondongwe 2011). In order for the gospel to grow ‘deep roots’ and bear fruit within MEM Societies of MCZ, the church had to inculturate the gospel.

Although this study utilises the concept of ‘inculturation’ as a theoretical framework, Shorter (2006:10) argues that it is not the most accurate term possible. Shorter cites Pope John Paul II who describes inculturation as a “neologism” (a new coined word) many people find ugly (Shorter 2006). Another limitation of the concept, according to Antonio (2006:29), is that the word has no proper definition. According to Hesselgrave and Rommen (2000: ix), inculturation has diverse meanings from one scholar to the other (see also Bowie 2011:67). It could be argued that this challenge of finding consensus in the definition from recent scholarship has weakened the concept of inculturation as a legitimate accompanying lens and conversation partner with the missio-cultural theoretical framework for this study. Nevertheless its strength far outweighs its weaknesses and therefore it serves as the preferred term to be used in the missio-cultural study of the selected societies of MCZ. “Since inculturation embodies the interaction of culture, gospel and the dialogues and engagement format it makes it a process that never ends because cultures are constantly changing” (Arbuckle 2002:18). This advantage provided inculturation with enough flexibility to converse with this missio-cultural phenomenological study.

The way in which MCZ selected societies are faced with the missio-cultural challenges posed by the healing ministry has been exacerbated by the postcoloniality environment in which the church has found itself. Church members are asking many questions on the relationship between their faith and culture. Antonio states that “many thematic concerns of inculturation are also those of the postcolonial theory” (2006:1; Magesa 2004:50). Antonio further argues that inculturation and postcolonial¹³ discourse cannot be artificially separated and that Africanism is the mode through which inculturation participates in postcolonial discourse (2006). The link between the two is thematic, political and methodological. Politically, both seek to make sense of how the current global political and cultural situation can be understood because of previous colonial relationships. The working definition of this

¹³ According to Gandhi (1998:5), “postcolonial reflects on the colonial past. It is a process of returning to the colonial scene and disclose a relationship of reciprocal antagonism and desire between the colonizer and the colonised”. Sugirtharajah (2006:64) claims that postcolonial has become a profitable alternative theory to uncover colonial domination in all its forms. However, Sugirtharajah concludes that post colonialism is a notoriously loose term covering a multitude of intellectual and textual practices, thus each discipline has to come up with its own definition (:64).

research is the one provided by Hewitt (2012:18) when he argues that “inculturation is the ongoing dialogue of Christian faith with a particular culture”.

1.8 Review of Literature Pertaining to Key Concepts

The underlying research problem that this thesis was seeking to address engages insights of scholarly literature on the subjects that cover the key concepts related to MCZ and healing ministry. The literature reviewed gave some insights into the missio-cultural concept of the healing ministry in the MEM societies of the MCZ. This literature also informed research on the gap that has to be filled by this phenomenological study on the mission of MCZ.

1.8.1 Methodist Church in Zimbabwe

Literature on the community of faith identified as ‘Methodist’, is divided into the global Methodist community and the Methodist Church in Zimbabwe. John Wesley, the founder of Methodism, had a deep passion for faith healing. According to Hughes (2007:3), “Wesley’s theology as a practical piety is grounded in the holistic soteriology”. He was concerned about both medical and spiritual healing. Hughes further argues that, “health was bad in the eighteenth century and people came together to fight the health challenges of their day. They encouraged each other to visit the medical professionals” (2007:3). In a society of sickness, Hughes comments that people availed themselves of everything to be well (2007:24). Wesley’s theology of healing defines the health ministry for Methodist Church. According to Holifield (1986:44) , Wesley’s health responses is understood in terms of healing ministry and healthcare ministry (see also Dickinson 1995:174; Stacey 1988:138; Madden 2010:176).

Atkins (2011:48-54) argues that “contemporary healing in the Methodist Church is understood in four ways namely: healing, holiness, wholeness and salvation”. These four are regarded as commonly rooted in the ministry and mission of Jesus Christ. The Methodist Church in the United Kingdom, where MCZ came from (see Gondongwe 2011) made a statement that healing is present in fellowship, pastoral, worship, preaching, sacraments, and social ministry of the church and that ministries are the church’s normal activities and all its members are called to be involved in them (Methodist Church – British Conference 1977 article 18). This healthcare statement is important to this missio-cultural phenomenological study because MCZ was under direct theological influence of the British

Church before it gain self-rule in 1977. Therefore the healthcare statement should have also impacted the understanding and practice of the healing ministry in MCZ

Methodism came to Zimbabwe in 1891 with the missionaries from Britain. The church became autonomous¹⁴ from the British church in 1977 (MCZ *Deed of Church Order and Standing Orders* 2007:1). The missionaries left a constitution driven by the Western culture where healing is not clearly defined. The constitution is however very clear on the sacrament of Baptism and Holy Communion but silent on healing ministry (2007:1). This *missio-ecclesiae*¹⁵ and Euro-centric worldview communicated the African context as a dark continent that should be won to Christianity and made civilized. As such, the Western missionaries introduced medical and educational missions as an invaluable evangelistic agent (Zvobgo 1996:202). Their biggest challenge was to understand the culture of the local people (Mbiti 2000:88). According to Gondongwe (2011:62), the missionaries established mission hospitals, but many Africans chose not to seek medical attention from the Western institutions; rather they continued consulting their own traditional sources that served them for generations. They regarded diseases as caused by witchcraft, the living dead or avenging spirits and yet the missionaries had no solution to these spiritual phenomena (see also Zvobgo 1991; Moyo 1987:62). Gondongwe further observes that “Africans doubted the efficacy of Western medicine on the grounds that it was believed to concentrate on the symptoms of the disease leaving out the metaphysical cause. However, Africans continued to visit the mission hospitals because it was mandatory by the missionary policies” (2011:64). Since MCZ policy is passive on the healing ministry phenomenon, some members have opted for other ecclesial health solutions outside of the MCZ.

What seems to be more challenging for MCZ members is that, although there is no official literature of MCZ that explains its understanding and practice of the healing ministry within Zimbabwe, members have a wide range of choices available to them. The first one is the African traditional way of interpreting and practicing the healing ministry. According to Oosthuizen *et al* (1988) “since in Africa, any illness is ascribed to a disturbance of a balance between man and the spiritual forces, the aim of health is seeking to restore the equilibrium”. In addition, Shoko (2007:58) states that “illnesses in Africans is caused by the angry

¹⁴ Autonomy means the Methodist Church became an independent Conference from the British (Zwana 2011).

¹⁵ According to Vestraelen (1995:174), *missio-ecclesiae* means the expansion of the church as a unique salvific institution.

ancestors interested in the affairs of their descendants. These ancestors also bring misfortunes, barrenness or even death and wellness and health are attained by appeasing these ancestors and traditional healers are often consulted”. Given the non-availability of healing ministry in MCZ, some members are taking this route.

Second, some members visit AICs to access their healing ministry. Gundani (2001:140) maintains that “healing methods in these churches are similar in some ways to those of the traditional healers, since they both emphasis exorcism and extraction of pathogenic objects from the clients”. The third option for MCZ members is to go to the Roman Catholic Church where the sick are anointed with oil during the prayers. The fourth option is to join the newer Spirit-paradigm churches such as the charismatic movements and Pentecostal churches where faith healing is central. Lastly, MCZ members also go to the hospital; however, given the continuous decline in the economy of Zimbabwe since 2000, many are unable to pay for their healthcare and so end up accessing the first four suggested routes in their quest for healing. According to Healey and Sybertz (1996:304), the mainline Protestant churches continue to hesitate to officially participate in the healing ministry. Such a situation has left MCZ members with a challenge of how to deal with their quest for healing.

1.8.2 Healing Ministry

According to Shorter (1977:60), “sickness and healing for the African is a denunciation of life, a threat posed to life and healing is an active second to that of giving life.” Healing has been an integral part of humanity’s religious quest. In a way, healing is a theological issue because everyone with illness seek that help from God (Kydd 1998:19). Amanze (1998:175) argues that healing corresponds with the ministry of Jesus where it is seen as part of God’s overarching missional gift of fullness of life for all that became central to the mission of Jesus (see also McNutt 1988:22). The healing in MEM societies of MCZ on the other hand must find contextual relevance for a people shaped by traditional African religious worldview (see Ugwu 1998:17; Echema 2006; Oosthuizen *et al* 1988:15). MCZ healing ministry and mission in the three selected societies must therefore become fully enculturated¹⁶ if it is to be meaningful to the people. The challenges in the healing ministry

¹⁶ According to Shorter (2006:11), inculturation is the ongoing dialogue between faith and culture or cultures. In this research, inculturation will be used as a lens of missio-cultural theoretical framework to enable the MCZ mission to create a dynamic relationship with culture in the quest for healing ministry by its members in the selected societies.

faced by MCZ as described by Dickinson (1995:2) constitutes a quest for a miraculous healing which is sometimes called “faith or spiritual healing” (see also Anderson 2002:523). This quest for healing by MCZ members has led some to transfer their membership totally to the spirited-emphasis churches to fulfil their needs while others have maintained dual membership (see Louw 2007; Manala and Theron 2009; Gundani 2001).

Van den (2012:11) argues that “faith communities and religious institutions play a major role in assisting African believers to find health, healing and completeness in everyday life”. However, she laments that “the churches founded by missionaries seem to fail in addressing the believers’ needs for healing” (2012:11). MCZ, being a Euro-centric missionary-founded church finds this healing ministry challenging in the cultural environment in which it serves. Thomas observes that “healing ministry is still needed because it obeys the teaching of Jesus’ offer for life in fullness” (2010:1). The literature within the Methodist Church presents a narrative description of Wesley’s theology of healing and how the missionaries appropriated it in different geographical location. However, the literature has not engaged with a missio-cultural understanding of the MCZ perspectives and practices of healing. It could be argued that in the quest of Methodist theologians to remain faithful to Wesley’s teachings they became myopic in their theological reflections to move beyond the contextual limitations of Wesley and to appropriate the teachings of Jesus and appropriate the local resources in fashioning a contextually relevant understanding and practice of the healing ministry. It is this gap that this thesis aims to address.

1.9 Summary of Chapters

In keeping with the research objectives, the study consists of nine chapters that follow the following structure: Chapter one is the general introduction of the study. It identifies the research problem, research question, objectives, and the theoretical framework and reviews some literature relevant for the study. Chapter two traces the development of Methodism in the eighteenth century and the condition of healthcare resources in England during John Wesley’s time. His participation in the health fraternal, his personal experience, his theology of healing ministry and challenges experienced in the healing ministry were also explored. Chapter three constitutes missionary approaches to healing ministry in Zimbabwe. The chapter also delineates the rise and fall of medical missions in Zimbabwe. Chapter four explores the conflict between the Methodist missionaries’ healing traditions and the African healing methods. Chapter five presents an investigation of the healing ministry in the

autonomous Zimbabwe. The chapter critiques the MCZ response to healing ministry and the British Methodist's statement on healing ministry. The chapter concludes by analysing the further divisions in the independent MCZ leading to the formation of indigenous churches. Chapter six explores the contemporary healing ministry challenges that MCZ is facing. Chapter seven constitutes the research design, methodology and methods that were used in the study. Chapter eight presents the data analysis while chapter nine presents the general conclusion, research findings, contribution to new knowledge and gaps for future research that were identified.

CHAPTER TWO

METHODISM, HEALTH AND JOHN WESLEY

2.1 Introduction

This chapter presents a brief examination of the foundation of Methodism by John and Charles Wesley in the 18th century (Heitzenrater 2013:27). Although the Methodist Church in Zimbabwe (MCZ) mission started a century after Wesley's death in 1791 as an Anglican priest, yet, his theology continues to define the theological orientation of MCZ today. The study also analyses the condition of health services in England during Wesley's period and how it influenced his venture into medical healing ministry as an Anglican clergy. Furthermore, the chapter explores Wesley's efforts to respond to the medical challenges of the poor people in the eighteenth century England and his claim to conduct miraculous healing of his horse three times. The section concludes by analysing the influence of Wesley's life, theology and teachings on healing within the societies of the MCZ.

2.2 A Brief Overview of the Development of Methodism in England

According to Miller (2003:9), Methodism was founded by John¹⁷ (1703-1791) and Charles Wesley (1707-1788). John's commitment to the Methodist movement, ideology and theology has bequeathed greater recognition to him than his brother Charles (Mujinga 2017: xvii). "John started his education at the Charterhouse School in London at ten and half years and then left Charterhouse for Christ Church, Oxford in 1720" (Muller 2003:18-20). "John remained at Oxford until he was ordained firstly as an Anglican Deacon in 1725 and secondly as a priest in 1728" (2003:27). The two brothers grew up in an Anglican religious environment and they both later became Anglican Priests until the last days of their lives (Snyder 1980:18). Having received his Master of Arts degree in 1727, John considered the

¹⁷ The history of John Wesley and Methodism has been oversubscribed such that it is not very important to labour much on the already researched area. The research conducted by Maddox (2016) *Recent Dissertations in Wesley Studies: 2001–2016*, demonstrates that there were over 118 theses in Wesleyan studies in the period under study. However, these works are not a representation of Wesleyan studies, first, because they are only PhD theses from North America and European universities, and second, they are works accessible online only. The fact that there are countless books on Wesley and Methodism that include Master's Research from all continents and PhD theses from Africa, Asia and South America universities is a clear testimony that the history has been overdone. This research will trace the history of Methodism with a bias towards Wesley's healing ministry since this is the focus of the study.

invitation of his father to assist him as a curate in Epworth and Wroote, and in 1729, he left for Epworth. On his return in 1729, he found that Charles had formed a club that met for Bible Study, prayer, fasting, visiting and helping the needy who included the prisoners (Heitzenrater 2013:38). John Wesley joined the club in 1730 and became its leader. “The club was later nicknamed the Holy Club, the Bible Moths or Methodists with Methodists becoming the common derogatory name given the way they were conducting their services” (2013:40).

In 1735, John Wesley went to Georgia in the United States of America with Charles, Benjamin Ingham and Charles Delamotte. These four Holy Club members travelled together with Moravians and English colonists on board (Miller 2003:44). There was a terrifying storm in the Atlantic Ocean that disturbed Wesley’s faith. The storm sent waves over the ship that split the mainsail and damaged the deck. While the English passengers screamed in fear for their lives, the German Moravians calmly continued to sing the psalms (Miller 2003:50). After the storm passed, another spiritual storm emerged in John’s life that refused to be calmed (:50). John was challenged by the calmness of the Moravians during the physical storm that demonstrated they were not afraid to die. This was the first time the Moravians profoundly influenced Wesley’s religious life. This experience created a vacuum in his spiritual life. Wesley’s soul-searching exercise came to its climax with the Aldersgate Experience of May 24, 1738. During the service, Wesley wrote in his *Journal* of May 24, 1738 that “*I felt my heart strangely warmed. I felt I did trust in Christ, Christ alone for salvation and an assurance was given me that he had taken away my sins, even mine and saved me from the law of sin and death*” (Wesley 1738:36). The ‘conversion experience’ transformed John from being a pulpit preacher to a field itinerant preacher. This was very significant since it was such a great departure from the parish-station norm of clergy life (Miller 2003:62).

Wesley’s health problems at Oxford University and the Aldersgate experience focussed his attention on his own need of healthcare solutions. Although the Aldersgate experience provided solace for his spiritual life, his physical health and the healthcare of the poor in England remained a challenge for him. It is therefore prudent to suggest that Wesley’s approach to healing ministry was in part driven by his own life experiences. Maddocks argues that Wesley’s conversion of 1738 was “total” because it affected his entire being. Salvation by faith that he later proclaimed was nothing less than the salvation of the whole

human being (1988:139). The New Testament healing narratives of Jesus point out that the phenomenon of healing and salvation are integrated and this was central to his healing ministry. Wesley's conversion experience launched him into a holistic model of ministry that had a profound impact throughout England. After the Aldersgate experience, Wesley followed the pattern of Jesus's ministry by not only preaching but also ministering through healing and salvation to the needy people (1998:139). According to Maddocks, "this was the fire that burned within him, the fire that warmed his heart in Aldersgate Street and the fire to preaching, healing and the proclamation of the gospel by word and deed" (1998:139-140). Health and healing of the people became the primary purpose of Wesley's ministry and the route through which to address the salvation of their souls (1998:140).

2.3 The Conditions of the Healthcare System in England during the time of Wesley

The condition of the healthcare system in England during the time of Wesley is very significant in this study given that healing ministry in Zimbabwe in general and MCZ in particular was influenced by the deteriorated healthcare system. It is therefore important at this point to analyse the conditions and healthcare methods in England during the time of John Wesley in order to appreciate the extent to which these conditions contributed to the formation of his theology of healing ministry. The health system in England during the time of Wesley was very bad, with the health services inaccessible to the poor. Many diseases resulted from overcrowded insanitary dwelling houses, among other challenges that included the health institutions that were subjected to filthy conditions (Marquardt 1992:29). Hospitals and infirmaries were dirty with beds covered with straw mattresses and dirty linen and were breeding-grounds for different types of diseases caused by fleas, mites and lice (Hill 1958:3-4). In spite of this bad socioeconomic condition, it was more disturbing that England was hit by a scarcity of physicians, with Oxford producing only four doctors per year; Cambridge could produce more while Edinburgh produced the most, an average of sixteen per year (Hill 1958:3). The only health advantage in England was that there were apothecaries¹⁸ and surgeons scattered about in the more populated centres (1958:3). Added to this inadequacy of doctors was what Wesley defined as "the approach used to study medicine" (1958:3). For Wesley, "the type of training offered by the official was the

¹⁸ "Apothecary" is one term for a medical professional to refer to druggist or a pharmacist (Webster's New Encyclopedic Dictionary 1993:46).

contributor in producing incompetent healthcare practitioners because the medical students were spending too much time in philosophical theories of diseases, astronomy and astrology and neglecting the important areas of anatomy, psychology and the factual causes of diseases. This negligence was also affecting the kind of drugs distributed by the pharmacopoeia of which were of therapeutic value” (Wesley 1747: vii; see also Health and Healing 2001). Wesley’s records in his *Journal* of May 12, 1759 described how the poor were ill-treated by medical doctors and how these physicians disrespected the services of the priests. He complained that “most physicians were negligent and they prescribed drugs continuously without properly diagnosing the ailment” (Wesley 1759:146). He suggested that medical professionals consider calling the assistance of a clergy who should in turn call in the assistance of a physician (:146). He concluded that lack of compassion by the physician was because of their lack of faith in God (:146). For Wesley, being a Christian was a criterion of being a physician.

Similar to the contest of Wesley’s nation, the high cost of living in Zimbabwe has also resulted in many Methodist members along with the poor of the nation suffering medically because vital drugs are expensive and not available (Health and Healing 2001:4). In the interpretation of Wesley, it seems like in his nation good health-care was not meant for the poor and the uneducated to access but for the rich and the educated. Amidst these living conditions, Wesley was the trailblazer in seeing the health needs of the poor. He argued that not only do they need alms and objects of charitable care, genuine love and care but they need good health” (Marquardt 1992:27). In view of his concern for the poor, Wesley undertook various measures to respond to the need. Being aware of the unbearable conditions under which the poor people lived, his model of ministry was intensively practical, including feeding, clothing, healing and housing the poor. He not only addressed their physical needs, but he actually lived with the poor. There were several occasions when he even put his life in danger by being close to those with communicable diseases” (Health and Healing 2001:4). This was not surprising since he had decided to take the healing approach of Jesus that included rehumanizing the dehumanized sick of his day (see the Synoptic Gospels).

An example of this disconnectivity with the contemporary needs of people is observed in the disengagement of MCZ societies towards many people living with HIV and AIDS within their contexts (see chapter 5, section 5:8). The affected persons are separated from

the mainstream healing ministry theology of the church (Mujinga and Moyo 2016:57). This attitude to the healing ministry represents a denial of the heritage bequeathed by Wesley who inquired about the wellbeing of those who were ill, whether they were warm enough, well fed and clean (Marquardt 1992:30).

According to Huges (2007:5), “Wesley was critical of the pharmaceutical industry of his context, fearing that the poor people were being given poisonous substances and being overcharged by the medical fraternity who had financial interest in this industry”. Wesley felt that “apothecaries were combining too many ingredients in order to swell their bill and possibly on purposes to prolong the distemper that the doctor and the apothecary may divide the money (2007:5). His response to the corrupt healthcare system led him to take initiative in the health challenges of the poor with the help of an “assistance in apothecary and an experienced surgeon. He referred, all difficult and complicated cases to specialist physician of the patient’s choice (1746:264). He also took upon himself to give them the best medical advice that he could and the best medicine he had (Wesley 1746:264). An analysis of the healthcare conditions during the time of Wesley shows that the poor were meant to languish with their diseases. Wesley in turn offered medical advice and also prescribed what he thought was the best medication. His reading of George Herbert’s (1652) book reinforced his commitment to the healing ministry to the poor. Herbert argues that:

A parson is exact in the governing of his parish, making it a copy and model of parish. He knows the temper and pulse of every person in his house... if there is any of his flock that is sick, he is their physician... if he or his wife does not have the skill, he keeps some young practitioners in his house for the benefit of his parish... if not then he keeps good correspondence with some neighbouring physicians for the cure of his parish (1652:94).

Along with the poor general health conditions of England, Wesley’s own experience of illness and that of his family influenced his healthcare approach. An example of his family healthcare needs is expressed in his father’s mail to a friend in 1692 expressing the health problems that Susanna experienced, claiming that she had been “sickly, having had three or four touches of her rheumatism¹⁹ (Wallace 1997:8). In Susanna’s correspondence, there is continuous mention of her bouts of illness, though usually without any specific description (Wallace 1997:9). In early 1722, she wrote to her brother stating that “I am rarely in health”

¹⁹ Rheumatism refers to the disorder of the muscle, tendons, bones or nerves characterized by pain, disorder and disability.

(1997:9). In a letter to Charles (well after her husband's death in 1735 and her departure from Epworth), she commented again on her poor health arguing that, "I should write oftener had I better health"²⁰ (Wallace 1997:10). Wesley did not only have passion for the healthcare of the poor people in England but particular concern was for his mother whose healthcare challenged the authenticity of his ministry. "Susanna was one example of the poor who suffered health challenge because of the primitive state of sanitation, medicine and birth control of the eighteenth century" (Wallace 1997:10).

Wesley's poor health was also confirmed in a letter to his mother in 1723 in which he told her how he almost choked from bleeding while walking in the country (Miller 2003:20). In 1752, he became very ill to the extent that he thought he was going to die. The depression through his ill-health led him to write his epitaph which he ordered should be placed on his tombstone. He recorded in his *Journal* that:

...My cough did not interrupt me while I preached in the morning; but it was extremely troublesome while I administered the sacrament ...about noon I took coach for Lewisham. In the evening (not knowing how it might please God to dispose of me), to prevent vile panegyric, I wrote as follows: 'Here lieth the body of John Wesley ...who died of consummation...God be merciful to me an unprintable servant (Wesley 1754:154).

Wesley's poor health condition led him to combine medication with his own faith in God. Another *Journal* entry stated that:

On Wednesday, 28.-I found no change for the better, the medicines which had helped me before was no longer effective. About noon a thought came into my mind to make an experiment. So I ordered some brimstone to be powdered, mixed with the white of an egg, and spread on brown paper, which I applied to my side. The pain ceased in five minutes, the fever in half an hour; and from this hour I began to recover strength. The next day I was able to ride (Wesley 1754:154).

The discussion of Susanna and Wesley's healthcare challenges deeply influenced his participation in the healthcare fraternity. He combined the medical with the spiritual discipline of prayer as his healing strategy. His *Primitive Physic* text in 1747, affirmed the

²⁰ See the following letters written by Susanna to her three sons Samuel Jr, John and Charles expressing her ill-health. 27 November 1707; 14 February 1708/09; 20 January 1721/22; 10 September 1724; 23 February 1724/25; 26 July 1727; 12 August 1728; 11 August 1729; 21 February 1731/32; August 1737; 6 December 1738.

combination of the introduction of dispensaries with the necessity of pastoral visits by lay people as the strategy to overcome health challenges.

2.4 John Wesley's Participation in the Health Fraternity

Wesley's interest in the public health fraternity was motivated by family experiences. "Bartholomew Wesley (Wesley's grandfather) practiced as a physician while rector of Charmouth in Dorset" (Maddox 2007:5-8). When Bartholomew eventually refused to sign the *Act of Uniformity*²¹ to the Church of England and was excommunicated, he later worked as a physician and as an alternative/second career (2007:5-8). Likewise, Dr Samuel Annesley – the father of John Wesley's mother (Susanna) – had a library which had over twenty volumes on medical references that Wesley made use of, and fast tracked his readiness at the age of 17 to attend Oxford University, qualifying him to start his healthcare activities in 1729 (2007:5-8).

In addition, Wesley was inspired by his studies as an Anglican theological student at Oxford University in the 1720s (Madden 2004:743). According to Maddox, "medicine was part of the Anglican clergy candidates in the seventeenth century. In the small villages that dominated England's landscape, the priest was often the most educated thus it was common expectation for them to be able to offer informed advice about treatment of ailments and promotion of health as part of their overall ministry" (2008:15). Maddox further argues that "the word *physic* or *physician* did not describe the person who administered medicine or did surgery rather it was ascribed to one who gave advice about how to maintain health and then one would go to a local apothecary or to a barber-surgeon for medication" (2012). "Although priests were regarded as benevolent amateurs in medicine, their role as 'fathers' to their community meant that they could legitimately dispense simple remedies" (Madden 2004:743).

²¹ "The Act of Uniformity was introduced by Queen Elizabeth who was the Head of State and Church in 1559 as a parliamentary measure for the Church of England to settle the religious question. It was a framework for the English religion for generations to come because it defined the standards of liturgy and doctrine requiring the church to use the Book of Common Prayer. The Act of Uniformity compelled the clergy and other officials to the doctrine in the Thirty-Nine Articles of religion and providing a standard exposition of accepted teachings" (Heitzenrater 2013:10).

The theological curriculum gave Wesley a new definition of health, such that in his 1759 sermon on Original Sin, he persuaded his followers to call the Great Physician of souls who would apply his efficacious medicine to heal the sickness caused by the first parents-Adam and Eve (Madden 2008:6). Wesley believed that medicine would restore the human nature in all its faculties and through Christ all sicknesses, spiritual, emotional and physical, would be healed with human beings returning to the pristine state (2008:5). Wesley's medical studies combined with his theological studies coincided with dramatic shifts in science in a society plagued with different kinds of diseases that made many people ill (Hudges 2007:5). During the seventeenth and eighteenth century, the clergy offered simple medical care in the remote smaller villages in which they served (Maddox 2007:7). As such Wesley read extensively to prepare himself medically in case there were no physicians in the Georgia colony (Marquardt 1992:28) where he served. "He learnt how to prepare plants and herbs that grew in the New World and their medical usages, so that he could give this kind of advice to his followers" (Maddox 2012).

In keeping with the quest to provide healthcare advice, Wesley was well prepared. His diary at Oxford records numerous medical treatises that he purchased and/or read between 1724 and 1732 (Maddox 2008:15). During his service as a missionary priest in Georgia, Wesley continued reading medical texts including that of Thomas Willis (1621–1675) and Robert Boyle (1692). In this book, Boyle noted that "Anglican bishops had authorized his work to be used by the clergy in their dioceses because healing became part and parcel of the Anglican pastoral care in the Church's practice of dispensing medical licences" (1692).

In 1730, Wesley also read Dr George Cheyne's book where Cheyne argued that it is easier to preserve than recover health and to prevent than to cure diseases (1724:7). For Cheyne, in order to preserve health, the quality and nature of food must be proportioned to the strength of digestion. The book condemns eating anything salty or with high seasoned pork, fish, and stall-fed cattle (1724:23 see also Wesley 1747:5). Cheyne recommended the food of any animal than the animal itself. He also encouraged the drinking of two pints of water and one of wine in twenty-four hours (1724:34). In addition, Cheyne prescribed food in place of medicine and also discouraged people from catching cold (1724:129; see also Wesley 1747:6). When Wesley wrote the *Primitive Physic* in 1747, he was motivated by Cheyne, who wrote: "I thought that I could spend my leisure hours better by putting together most general rules for those who are tender and sickly and labour under chronic distempers

... I could, for the benefit of those who may want them and yet not had such favourable opportunities to learn them” (1724:2).

Cheyne’s book created in Wesley a strong passion to attend to the healing needs of the people and above all to encourage them to use all the natural means of being well, like exercises and eating health food (Wesley 1747:12). Wesley read other medical books written by John Allen (1730), George Cheyne, “*A New Theory of Acute and Slow Continued Fevers*” (1702), John Drake, “*Anthropologia Nova; or, A New System of Anatomy*” (1727–1728), John Huxham, “*Essays of Fevers*” (1755), Hermann Boehaave, a Dutch chemist’s book titled “*Het, Nut de Mechanistische Methode in de Geneeskunde*” (1703), Richard Mead, *A Short Discourse Concerning Pestilential Contagion and the Method to be used to Prevent it* (1722), Dr Samuel Tissot, *A Treatise on the Disease Produced by Onimism* (1760), Thomas Sydenham, the founder of clinical medicine and epidemiology’s book, *Fevers* (1676) (Biography of Thomas-Sydenham-Observationes-Medicae 1760). This book by Sydenham was regarded as an essential medical textbook for students and doctors for two centuries and prescribed the use of iron in treating iron deficiency anaemia. Sydenham also helped popularize quinine in treating malaria. These medical texts played an important role in making the healing ministry central in Wesley’s ministry.

Wesley’s passion for health and healing was a central dimension of his ministry and mission in the development of early Methodism, in 1741. “He identified congregants within each society in London and instructed them to check regularly on the sick in their group and to offer them assistance” (Maddox 2007:6). This office of the ‘visitor of the sick’ was formalized in all the societies (Maddox 2008:18). “At the 1744 first Annual Methodist Conference, those holding the office of ‘visitor of the sick’ were charged to do pastoral visits to the sick in their area three times weekly, to enquire the state of their soul and their bodies and to offer them or procure advice for them in both regards” (:18). This study will later argue that this office still has a very important role to play in developing healing ministry within the MCZ (MCZ Class Book 2014:5). In the 1745 Conference, the lay preachers who assisted Wesley were instructed to visit the sick (Maddox 2008:10). These leaders were given the mandate not only to advise but also to dispense the medicine to the poor people in Wesley’s fellowship (2008:10). Wesley also noted that even the lay preachers had a limited range of medical knowledge; the next step that he took was to start publishing a distillation of his study area” (Maddox 2008:10).

According to Maddox (1994:146), in Wesleyan theology, “spiritual healing contributed to good physical health” (Maddox 1994:146). For him, “both spiritual and physical health are tangibly related and therefore both need pastoral and medical care” (Hudges 2007:8). Hiatt (2008:4) comments that “Wesley’s model of healing covered the multidimensional aspects of physical, spiritual and relational healing”. Maddox further confirms that “health and healing of the people to whom Wesley ministered was always the purpose of his ministry and was centred on the salvation of their souls and their physical wellbeing” (Maddocks 1988:140).

2.5 Wesley’s Efforts to Respond to Health Problems of the Poor in England

2.5.1 Wesley’s Intellectual Therapy: The Primitive Physic 1747

Wesley’s first step to help the plight of the poor people was to ensure that they had access to medication and that they were adequately informed about their health situation to help them make informed choices. People came to Wesley to inquire about their bodily and spiritual health for which he gave advice and offered relief (Madden and Vickers 2010:179). In order to aid this process, Wesley prepared and published a pamphlet, entitled *A Collection of Receipts (or Prescriptions) for Some of the Common Health Ailments* (1745) based on his own medical reading and experiences (2010:179). This pamphlet was sold for a penny to allow the poor to access this valuable medical manual (Maddox 2008:18). The socioeconomic conditions that created the reality of the suffering poor in England speaks also to the contemporary context of Zimbabwe and the ministry of MCZ where many people struggle with their health needs while the rich spend resources abroad on their healthcare.

Wesley’s medical text, *Primitive Physic: or an Easy and Natural Method off Curing Most Diseases* (1747), contained a list of nine hundred recipes for medical remedies and practical directions on how to cure a larger number of disorders (Bertucci 2007:347). The title suggests that Wesley used the concept of primitive to connote what is original rather than what is archaic. Biblical narratives also describe ancient settings of healing (Rev 22:2). Therefore for Wesley, *Primitive Physic* was both a medical and theological healing manual for the poor in which he offered medical advice that had been used for generations (Maddox 2012). For example, Wesley argues that diabetes is a frequent and large discharge of pale and sweetish urine, attended with a constant thirst, and a wasting of the whole body (Wesley 1747:74). For this ailment, he prescribed “wine boiled with ginger regularly, milk, water, a

quarter of a pint of alum posset, putting three drachms of alum to four pints of milk. It seldom fails to cure in eight or ten days (Wesley 1747:74).

Societies like Mbare have acted on Wesley's approach to natural medicine by planting herbal gardens as a way of inculturating healing ministry. The importance of the *Primitive Physic* must be viewed from the context of what motivated Wesley return to England after his mission in Georgia, USA. Wesley did not return to active parish ministry because he was excommunicated from the Anglican pulpits. Instead he started a revival movement and spent the rest of his life as a traveling evangelist-organizer. Wesley realized that his gatherings were supported by many of poor people who did not attend parish churches (Bertucci 2007). Many were sick, and since they did not attend church, they did not have the connections to get health advice from a priest and in addition they did not have money to visit a physician. "Wesley felt that he needed to care for these people, so he opened a clinic in Bristol and later in London, and a dispensary where people could get medicines" (Maddox 2012). It was in response to meeting the medical needs of a growing population of sick poor people that *Primitive Physic* was written (Maddox 2012). Wesley told his lay preachers to leave two books in every home for spiritual and physical care, namely, "*The Christian's Pattern*", his abridgment of Thomas à Kempis' "*Imitation of Christ*", and "*Primitive Physic*" (Maddox 2012).

"The *Primitive Physic* was affordable to the poor at a cost of one shilling as compared to similar texts that were expensive for the poor man/woman to buy and too technical in language usage for the ordinary person to understand" (Bertucci 2007:347; Madden and Vickers 2010:179). The book also contained Wesley's theological opinions on health and sickness. He argued that "diseases spread as a result of divine punishment and healing was a manifestation of God's mercy that allowed man to restore the pristine purity so hard to be understood as both a physical and spiritual process" (Bertucci 2007:347). In view of this understanding of sickness, one can safely conclude that Wesley's healing ministry had the poor and the weak at the centre.

Methodist stewards, who managed the affairs of the society were ministers to the vast numbers of the sick within their district, used the medical advice provided in the *Primitive Physic* to offer medical therapy at home and at a lesser expense (Maddocks 1988:140). This Home Based Care healing ministry enabled the sick people to receive the comforting care and support of their relatives. "The 'visitors of the sick' were compelled to visit the sick

within their pastorate two or three times a week and to help those who could not afford to buy the medication” (Madden and Vickers 2010:179).

Within the context of the MCZ, the failure to appreciate healing ministry was acknowledged in the 2011 and 2014 Minutes of Conference. This seems to suggest that John Wesley’s health heritage that was initially transported to Zimbabwe was never effectively transplanted in the MCZ ministry and mission within the local context. Whereas the MCZ focussed on the “Methodistness” of healing ministry, Wesley’s ministry was actually grounded more in healing than preaching and teaching (Maddox 2012). This emphasis reaped great results in the health fraternity led Wesley to comment that through the grace of God, many who had been ill for months and years were restored to perfect health (Maddocks 1988:140). Wesley attributed the healing to physic and prayer for God’s blessing of health (1988:140).

Although MCZ have not built up local literature to inform its healing ministry, the *Primitive Physic* intertwined the role of pastor and physician to combine simple traditional methods of healing with the new scientific and medical discoveries of Wesley’s days. This serves as a limited but important signpost to cajole the church into action (see Madden 2007:14). This missio-cultural study, therefore, questions the missional identity and vocation of the MCZ’s clergy whose Wesleyan heritage has bequeathed a pastoral focus on holistic healing towards the healthcare of the poor. Wesley considered that all kinds of ailments, emotional, physical and spiritual, as interrelated and need holistic remedy (Maddox 2007:14). For Wesley, prayer for miraculous healing was not only for the sick persons, but also for his/her personal healthcare. He gives an example when he had pain of the “tooth and he prayed with submission to the will of God and the pain subsided” (Maddocks 1988:140).

From Wesley’s actions, the healing of all kinds of ailments was oriented towards faith. The *Primitive Physic* relates one account in which Wesley prescribed two hundred and twenty-five treatments of which one hundred and eighty-four were from plants, seventeen from animals and twenty-four from minerals (Wesley 1747:65). It is probably against this background that Madden concludes that “*Primitive Physic* was the most popular medical volume published in the eighteenth century England” (Madden 2007:12). Moreover, for Madden, *Primitive Physic* combined the simple traditional medicine with the best scientific discoveries of his day because healing was central in his theology (Madden 2007:20).

Primitive Physic stayed in print the longest as compared to other Wesley's publications (Maddox 2012).

2.5.2 Wesley's Medical Therapy: Establishment of Dispensaries

The establishment of dispensaries was Wesley's second initiative to deal with the healthcare challenges of the poor of his time. In 1746, he mentioned to the society what he called "my design of giving physic to the poor" (Maddocks 1988:140). Wesley records in his *Journal* that, "in December 1746, thirty people came for medical attention, in three weeks about later on three hundred came, and it became a routine for several years and the number of patients continued to increase and yet the resources were not adequate. However, all the sick were given medical attention (1988:180).

The restoration of health is ascribed to faith, as the basic rule for Wesley's healing ministry. In dealing with the physical healing of the poor people of his day, between 1746 and 1747, Wesley founded dispensaries in London, Bristol and New Castle (Wesley 1746:11). Wesley's dispensaries treated greater numbers at little or no expense (1746:12). These medical centres have been claimed to be the first free therapeutic dispensaries in England (Health and Healing 2001). In this spirit of helping the poor, Wesley treated chronic diseases and referred acute ones to the licenced physicians (2001). Wesley used all curative methods and preventive advice to make the poor people well. For Maddox (2007:17-19) "in his health-giving prescriptions, Wesley included simple and natural recipes such as honey, treacle, vinegar, whey, clean air, salt, water, milk, vinegar, some common English herbs and safe medicine" (Wesley 2004:vii; Hill 1958:10).

Moreover, Wesley was happy that his movement practiced hospitality like the New Testament Church in Romans 16:1-2²² (Madden and Vickers 2010:179). Wesley soon discovered that the scale of the problem was much bigger than what he had originally anticipated. So many of the poor became sick whereas the cost and accessibility of medicine were far removed from their reach (1970:179). This situation forced Wesley to watch the poor people perishing and several families disintegrating because they were without basic

²² In this text Paul commends the church in Rome for receiving Phoebe in the manner they would have received the saints.

medicine for their illnesses. Finally, as a desperate expedient, Wesley resolved to prepare and give medical attention to the poor himself (1970:179).

2.5.3 Wesley's Scientific Method of Healing - Electrotherapy

Three themes emerge clearly from Wesley's medical community of the eighteenth century. "The idea of the well-working of the body as a whole, the view of 'sympathy' throughout one's total being, and a belief in the natural means of promoting health were critical for Wesley" (Ott 1991:45). Added to these was the scientific methods of healing that he introduced – this was electrotherapy. Wesley referred electrotherapy as "a thousand machines in one" (Wesley's *Journal* January 4, 1768; Malony 1995:1). In 1760, Wesley published on the use of electrotherapy (1995:1). "The book came as a result of Wesley's experience of the use of electricity in free medical clinics which he had established for the poor" (Bertucci 2006:341). "By offering healing, sparks and therapeutic shocks to the lower class, self-styled medical electricians extended electricity's audience beyond polite society (:341). "In society with poor medical facilities, electrical healing was advertised as a therapy for the poor, just as Methodism was a religion of the poor" (Malony 1995:3). From the statement of Malony, Methodism evolved out of the socio-religious plight of the poor masses. Healing ministry in the MCZ today should base on the same premises, where the poor occupy the centre stage of the MCZ mission.

According to Bertucci, "Wesley's practice as an electric healer had a distinctive 'religious utility', tightly connected with his theological views and his attempt to gain membership for the Methodist movement" (2006:342). "Wesley used electric type of healing mostly to the mentally challenged people. In the passage of time electricity became one of the most expensive healing methods available for use by anyone. Wesley bought his own electric machine in 1753 for his personal healthcare especially shocking some parts of his body" (Malony 1995:3-5). Later, Wesley provided these machines in his clinics, in London and in Bristol (:2). According to Maddox (2007:9-10), Wesley did not limit these remedies, but he also used pharmaceutical, emotional and spiritual treatment. At one time when his brother Charles was sick, he suggested a consultation with the physician, exercise on a wooden horse and electrotherapy. Wesley joined electroshock with other medicines as a means of

healing. He listed thirty-one disorders for which he thought electrification should be used²³ (Maddocks 1988:144). Malony concludes that “given the manner in which Wesley was experimenting with the electric machine for healing, he deserves to be classified among the four best known electrotherapists²⁴ of the eighteenth century” (1995:1). For Bertucci, “Wesley was either blessed as a ‘godparent’ of electrotherapy or blamed as an ‘unqualified practitioner’ with ‘prejudice against the medical profession’” (2006:342). For Wesley, there was no medication as good as electrotherapy.

2.6 John Wesley’s Theology of Healing Ministry

Wesley’s understanding of health and religion went hand in hand. According to Hiatt, “healing for Wesley is God’s intention to fulfil the original purpose of creation in reconciliation, revitalization, renewal and to overcome the rebellion caused by the fall of humanity” (2008:6). Wesley understood healing theologically and taught it because healing for him demonstrated the outward work of the holiness of the community of faith (2008:6). Maddox observed that Wesley responded to God’s commandment to love God and to love the neighbours through his participation in healthcare ministry (1994:147). Wesley’s belief in healing was part of the whole process of salvation since humanity was born with original sin. Before the fall, there was no place for physic or the art of healing as humanity knew no sin, pain, weakness or any form of body disorder” (Wesley 1747:7). Wesley bemoaned that,

nature also conspired to punish the rebelled humanity as such the sun and the moon shed unwholesome influence from the above the earth exhales poisonous damps from beneath, the beast of the field, the birds of the air and the fish of the sea are in

²³ Others disorders Wesley treated with electrification include, (fevers-malaria), burning sensation in limbs and extremities caused by a fungus, blindness, goitre, chlorosis (iron-deficiency anaemia), coldness of the feet which he called the (Raynaud’s syndrome?) consumption (tuberculosis), contractions of the limbs, cramp, deafness, dropsy, epilepsy, feet violently disorder, felons (abscesses), obstruction of the flow of tears, fits, ganglions (cysts around joints and tendons), gout, gravel (small kidney stones), headache, hysterics, inflammations, kings evil (scrofula - tuberculosis, neck glands), knots in flesh, lameness, leprosy, mortification (gangrene), pain in the back, in the stomach, palpitation of the heart, palsy, pleurisy (inflammation of the membrane surrounding lungs), rheumatism, ringworms, sciatica (pain, tingling in leg), shingles, sprain, surfeit (over-indulgence), swellings of all kinds, throat-sore, toe hurt and tooth-ache” http://electrocleansing.com/history_wesley.php retrieved 24 October 2016.

²⁴ According Bertucci, electrotherapy was first introduced by Richard Lovett in 1756 (2006:345). John Reddall asked Lovett’s advice for planning a course of lectures on medical electricity that attracted more than one hundred people a day some coming from the countryside. Reddall was the one who made electrotherapy cheap and affordable to lower classes. John Read was influenced by Lovett and Reddall and started his own business practicing and lecturing on medical electricity at the other end of town (2006:346). Electrical treatments were advertised as cheap, safe and easy (2006:347). What made Wesley to be counted among the best four was because he introduced electrotherapy to the Methodist; a movement for the poor (2006:347).

the state of hostility, the food we eat daily saps the foundation of life which cannot be sustained without it (Wesley 1747:7).

It is probably against this theological premise of sickness that Rieger and Vincent affirmed that, “in Wesley’s theology, healing takes place in God’s grace which makes one whole” (2003:103). In defining wholeness, the two scholars state that “this is the natural consequence of deepening the spiritual fellowship with God” (2003:104). In the Hebrew Bible, wholeness is expressed in the term *shalom* which is also the word used to express the idea of peace in Hebrew (2003:104). It is this quest for wholeness that Methodist members in MEM long for, as such they end up practicing dual membership.

Wesley believed that salvation is healing and healing expressed the transformation of full salvation (Hiatt 2008:8). In line with healing as salvation, Maddox maintained that, “Wesley resisted suggestion to abstain from providing medical guidance and to leave it to those certified by the college” (1994: 145). Maddox claimed without justification that Wesley did not take healing as an economical tool, but placed it in a theological understanding of salvation. Wesley placed health and salvation side by side to demonstrate that healing was part of the holistic process of salvation and salvation must involve both inner holiness and the recovery of actual moral righteousness in our outward lives (1994:145; Atkins 2011:48). For Ott, “the themes of salvation and healing were interconnected and given this symbiotic relation between body and spirit, a well-working body was fundamental to Wesley’s holistic view of health” (1991:44). Wesley’s belief of salvation as part of the whole redemptive process played a significant role in his combination of emotional, pharmaceutical, spiritual and natural remedies (Iyakaremye 2013:74).

According to Hiatt, people sought healing and wholeness through Wesley’s ministry for various physical distempers, and found relief and healing through his prayers and dispensing of medicine for divine healing (2008:100). Wesley taught that medical science cannot fully overcome human sickness because all causes do not lie within its borders. To bring about wholeness in a person’s life, there must be cooperation between the physical and the spiritual because the battle lies in both realms (Hiatt 2008:101). For Huges (2007:6), “Wesley gave preference to natural means of healing that includes herbs, plants and roots over modern ways of healing because he felt that using organic local ingredients honour God’s provisions for diseases” (2007:6). Wesley argued that “the poor and unlettered people, the sick and the seriously ill are not in a position to accept a faith that is only

cerebral; they need to be touched by the compassion of Christ at every level of their being. They needed the whole Gospel that will minister to their needs holistically for the healing of both mind and body and the soul and spirit” (Hudges (2007:6).

Moreover, Wesley also understood healing theologically and he taught that healing demonstrated the outward work of the holiness of the community of faith (2008:13). For Hiatt, Wesley’s healing terminology and metaphors expressed the good news of God’s salvation for humanity. Therefore healing in Wesleyan theology became the most appropriate way of expressing God’s loving, restorative, salvific work and throughout the fallen creation order (2008:13). It could be argued that both Maddocks and Hiatt’s arguments on Wesley’s healing ministry embodied the mission of Christ on earth. Unfortunately, the different ways in which healing ministry is understood and practiced in the MCZ seem to suggest that Wesley would most likely not approve of it today (see also Maddocks 1988:149).

2.7 Wesley’s Approach to Faith Healing

As discussed earlier, Wesley’s understanding of healing went beyond the physical human illness to include the wellbeing of the soul, that he called faith healing²⁵. Among some Christian communities, “healing is regarded as part of the biblical revelation, and reference is made to the Old Testament prophets, Christ himself and New Testament apostles who practised healing” (Anderson 2000:138). Following this pattern, Maddox argues that, “for every affliction, Wesley recommended the combination of medication with prayer, not only because he believed that God can miraculously heal, or that God provide the right medicine but also that because diseases are interconnected with the spiritual, emotional and general physical well-being of the individual” (2007:11). Thus for Wesley, prayer was the best medicine (Wesley 1747:9).

According to Dickinson, “Wesley had a deep interest in faith-healing and he considered prayer to be an appropriate response to illness. In some instances he thought God responded immutably to the prayer, through miraculous healing. In other words, God healed the body through the natural means of medicine and surgery” (1995:174). Wesley thought that “the

²⁵According to Daneel, faith healing is the concept whereby the adherents of religious faiths believe that their religious belief can bring about healing. Faith healing represents a more dramatic act of spirit expulsion. However, instead of praying to God, the priest, prophet or healer acting as exorcist commands the spirit invading the afflicted person to depart (1990:220).

sick had every right to appeal for miraculous healing, but that they should also have prudence to use medicine wisely” (1995:174). Wesley often prayed with the sick and also prescribed medicine for them. He did not favour relying on traditional treatments, rather medical care came first (Maddox 2007:9). An analysis of Dickinson and Maddox’s, statements presents us with Wesley who was committed to the power of faith and of science. However it remains unclear whether it was prayer or medication that came first for Wesley in the process of healing. It could be argued that it depended on the state of his mood that would determine whether prayer or medication would be a first priority. Wesley presents an example of how prayer works in relationship to medicine by narrating an account of one mistress in 1749 who could not heal after taking medicine but recovered after prayers (Health and Healing 2001:9).

Wesley also claimed that during his preaching “many people dropped down as dead and some would cry for their sins but after prayer, they would thank God for their forgiveness of sins” (Wesley 1742:59; Zivadinovic 2015:64). “Wesley spoke out against those who claim to possess healing gifts but misused them to the detriment of those who received the gift through fidelity to God in their ministry” (:64). He also acknowledged that some people possess some healing gifts although Wesley did not believe himself to have such a gift (Health and Healing 2001; see also Holifield 1986:36). Wesley also recognized the possibility of supernatural cures and he affirmed his belief that healing could be derived from either natural or supernatural, whether through medication or prayer” (2001). Within the context of MCZ and the wider Zimbabwean society, the inadequately equipped and expensive public healthcare system has driven many persons to resort to healing and deliverance ministries, although some members of the clergy have dismissed this model of healing as un-Methodist.

2.8 John Wesley’s Ministry of Healing and Deliverance

Healing and deliverance ministries are part of MCZ activities (See appendices 12, 13 and 14) that advertise Easter and other MCZ programmes. However, MCZ ministers do not share the same theological perspectives. Although some are convinced that healing ministry is MCZ’s core mission others view the ministry as a twenty-first century borrowed phenomenon (MCZ 2014). Jennings argues that “demons were just as real in Wesley’s days as they were during Jesus’ days” (2005:2). Wesley experienced several encounters with what could be classified as the supernatural which he claimed can only be dealt with through

the power of the Holy Spirit (2005:2). The focus of this section on Wesley's supernatural encounters is to make the case that such encounters are not unique to the contemporary context in which MCZ engages in the healing ministry.

2.8.1 Wesley's Experiences of Spiritual Warfare

Wesley's experiences of spiritual warfare include the Woodseat demoniac where a young girl was possessed and went into trance but was eventually healed after she cried for mercy (2005:4-48). The girl used to strip herself naked, frequently spoke like a second person and screamed for help. However she was prayed for and she became well (Wesley 1753:140). In another case of the Bristol demoniac, Wesley admitted that he was afraid and unwilling to contact the possessed girl but prayed from a distance while three or four persons held onto her especially when he called upon the name of Jesus for her healing (WJW 1:3). In dealing with spiritual warfare, Wesley believed in healing by prayer and would often hold days of prayer meetings (Zivadinovic 2015:53-71). On October 16, 1778, a woman who was sick for seven months immediately recovered after Wesley visited and prayed for her (Zivadinovic 2015:63; Wesley Diary October 16, 1778). These demonic encounters that Wesley experienced are not unfamiliar within the religio-cultural context of MCZ where all-night deliverance programmes are held during which members seek healing.

2.8.2 John Wesley's Encounter with Miraculous Healings

Wesley prayed many times for his own recovery and recorded that God healed him of the many infirmities in his life. For example, he was healed from a toothache after prayer (Zivadinovic 2015:64). Almost all of those who were visited by Wesley were restored to health and some even claimed supernatural healing after his touch (Wesley's Diary May 31, 1785; Zivadinovic 2015:63). In addition, he prayed for an insane man and he was healed on October 28, 1739 (WJW1:3). Of all the supernatural healings that occurred in the ministry of Wesley, the most fascinating ones are the incident of his horses that he claim were healed through prayers. Wesley's recordings in his *Journal* of Monday, July 1743 demonstrate how his horse was healed. This statement also justifies why he decided to embark on healing prayers and miracles for his horses in the future (Wesley 1743:69).

The different healing miracles of Wesley described in his *Journal*, demonstrate his complete trust in the sovereign power of God to bring about healing in both human and animal, which

are all part of his creation. According to Zivadinovic, “Wesley did not articulate the belief that one person has perpetual ability to heal under any circumstance, but that it is through compassion and faith expressed through prayer and supplication that will allow God to heal people. Healing only happens if God considers it beneficial to restore someone” (2015:64). These examples of Wesley’s experiences with the miraculous healings will serve as a template for reflecting on the healing ministries within MEM communities of MCZ where people are experiencing many threats to life.

2.8.3 John Wesley’s Encounter with Killing Spirit

During Wesley’s preaching, seven people fell on the ground and were in violent agonies. Wesley wrote: “the pain as of hell came about them, the snares of death overtook them. In their trouble, we called upon the Lord and He gave us the answer of peace” (WJW 1:3; Jennings 2005:64). Jennings drew a comparative analysis of John Wesley’s healing with the modern day encounter of healing ministry and concluded that “Wesley would not be expecting miracles to happen because of the influence of modern medicine and neither would he embrace the contemporary ministry and their magical actions where pastors cause unverifiable miracles to happen” (2005:71). However, contemporary pastors in the MCZ socialized around cultural expectations of healing will opt for a healing priority church (see also Jennings 2005). An analysis of Wesley’s acknowledgement of the presence of and encounter with evil spirits within his English cultural context serves as a signpost that the healing ministry challenges in the MCZ serves as a unique opportunity for the MCZ and its clergy to contextually appropriate Wesley’s healing legacy in confronting and exorcising the demons that are denying ordinary people’s fullness of life.

However, whereas the contemporary healing ministry within the MCZ is restricted to special events as advertised through programmes with special times allocated for church members, during the time of Wesley, the majority of these occurrences were aimed at and experienced by non-Christians (Jennings 2005:71). “People who sought healing from Wesley’s ministry did not pay for their healing neither did Wesley boast of his own ability to heal” (2005:71). Within the context of Zimbabwe, healing ministries are designed and implemented to achieve financial success for the owners of the ministries. Those who receive healing are expected to pay for their “blessing”. Such actions are open to corrupt practices with staged healing events supported by unscrupulous healers. It is probably because of this challenge that the MCZ Presiding Bishop warned that,

As we conduct healing services in our church, let us remember that our people know what they want and we must not take them for granted. Prayers and services for healing do not make anyone less Methodist. Imitating and replicating others and their ways of doing things means, 'we do not have the power or the spirit to heal (Ndhlumbi 2014:98).

This statement seems to suggest that the borrowed healing style has become rampant in the MCZ where people use all efforts, including financial enticements, in order to be "healed". Such actions have given rise to the birth of multi-religious faiths that are transported and transplanted into any faith community that meets the healing needs of people (Jennings 2005:71).

2.9 Healing Ministry after John Wesley

Wesley's healing ministry spread throughout Europe after his death in 1791. Maddocks (2007:9-10) argues that after 1791, people's interest in faith-healing increased. There was some heightened sense of expectancy about the supernatural activity of the Spirit and the growing interest in the extraordinary gifts of the Spirit, which included the gifts of healing (Dickinson 1995:176; Holifield 1986:39). Holifield remarks that "spiritual healing²⁶ remained as an undercurrent of piety" (:44). Wesley turned to the Doctrine of Creation and the Doctrine of Grace to anchor his teaching on the healing ministry. The doctrines form the central theology of Methodist of spirituality and health" (Dybicz and Ketchell n.d:2). Methodist theology of healing was also on the fall of humanity and God's grace to humanity. This grace was made possible by Christ's incarnation (Dybicz and Ketchell n.d:2). The wholeness of life of Jesus is expressed in John 10:10, where Jesus teaches about him being the giver of life in abundance.

2.10 Conclusion

Healing ministry was the primary call of John Wesley and he ministered to both Methodists and non-Methodists alike. Health for Wesley came before denominational faith allegiance. In his efforts to minister to the needy of England through medical healing, Wesley established dispensaries and wrote a manual on health entitled the *Primitive Physic* in 1747.

²⁶ According to Atkinson (2012:1), spiritual healing is not the same as curing. Healing is associated with the word whole. It is possible to be whole person even if one is not physically well. Atkinson thinks that it is possible to be a whole person whilst dealing with the physical deterioration of old age.

He also used an electrotherapy machine in order to alleviate the health challenges of the less privileged. Although Wesley did very well in the medical field, he faced opposition from the health fraternity. However, Wesley defended his ministry as one that was fulfilling Jesus' mission to the sick and the poor. The chapter concludes with an exploration of Wesley's understanding and practice of miraculous healings.

CHAPTER THREE

MISSIONARY APPROACHES TO HEALING MINISTRY IN ZIMBABWE

3.1 Introduction

The previous chapter presented an overview of the Methodist movement that was founded by John Wesley, the conditions of healthcare during his time, and the steps he took to help the poor people access health facilities. The chapter also examined some of Wesley's miraculous healings. This chapter will give attention to what happened to the healing ministry within Methodism after John Wesley, and how the faith was transported and transplanted by missionaries to Zimbabwe. This study asserts that missionary Christianity transported to Zimbabwe was influenced by deism as postulated by David Hume (1711-1776) (Latourette 2005:984). African Christianity planted by European missionaries was therefore clothed in western garments. Kaunda, commenting on the same subject, argues that "most African churches grew out of European experiences, rather than out of African experiences of God within their cultural traditions, religious past and existential realities. God was presented to Africans through European cultural symbols" (2016:3). Missionary Christianity therefore had a negative impact on the understanding of healing ministry among the Africans in general, and Zimbabweans in particular. In the view of the missionaries, anything that could not be proved scientifically was not an ailment (Madhiba 2000:25).

3.2 The Transportation and Transplantation of Methodism in Zimbabwe

The transplanting of Methodism to Zimbabwe cannot be separated from the colonization of the country (Zvobgo 1991; Banana 1991; Gondongwe 2011; Madhiba 2010). As early as 1795, Methodism reached South Africa with the British troops and settled in the Cape (Kumalo 2009:37). In 1880, Owen Watkins was sent to the Transvaal District²⁷, in South Africa to take the "Trial Mission"²⁸. When the South African Conference was started in

²⁷ Transvaal District had Pretoria as its centre. In the east, it covered Swaziland, and the western base was in Bechuanaland among Montsioa's people (Hewson 1950:47). Transvaal District is one of the Methodist Church of Southern Africa districts to be founded by the local people like David Magatha, Daniel Msimang, and James Allison, among others. The first Chairman and General Superintendent of the Transvaal was Owen Watkins who later crossed the Limpopo River to establish the Methodist Church in Southern Rhodesia (Thorpe 1951; Hewson 1950; Zvobgo 1991; Banana 1991; Kumalo 2009; Gondongwe 2011; Mujinga 2017).

²⁸ According to Veysle (1969:39), Trial Mission was a District established by the Wesleyan Methodist Missions Department in Britain to operate while the Conference was assessing to ascertain whether it would be possible to occupy a certain geographical area. The District was to operate under the British Conference and a case in point was Transvaal District (1969:39).

1883, Transvaal District remained under the British Conference (Cragg and Millard 2013:103). One of the reasons for leaving Transvaal District under the British Conference was that the financial support for the Conference was to be phased out gradually and it would not have been able to support the numerous churches that were planted in the Transvaal and later in Rhodesia (2013:103). Watkins was instructed not to cross the Limpopo since a number of missions were being opened in the Transvaal, and missionary income was declining (Thorpe 1951:39). Thorpe adds that Rhodes offered £100 a year towards Wesleyan ministry in the country (:39). The British Conference accepted this decision and Watkins was allowed to go further north into Mashonaland.²⁹

It is against this background that scholars argue that the roots of Zimbabwean Methodism were established in South Africa (Zvobgo 1991; Madhiba 2000; Gondongwe 2011; Makoti 2012). Owen Watkins and Isaac Shimmin arrived in Mashonaland on 29 September 1891 (Thorpe 1951:39; Linden and Weller 1984:81; Zvobgo 1991:6-7; Gondongwe 2011:46). With their arrival, Methodism began (Gondongwe 2011:46). Watkins and Shimmin obtained a concession from Cecil John Rhodes of three farms where the Methodist mission developed (Houser 2000:104). Madhiba (2010:107) claims that the establishment of the Wesleyan Methodist Church in the rest of Zimbabwe rested more on politics of land than evangelism. The land that was given was land taken from the local people by the colonial powers and transferred to missionaries. This is another form of land theft. It could therefore be argued that the Methodist mission in Zimbabwe began through unjust collusion with colonial powers that engaged in land theft from the local people to begin the mission (see also Hewitt 2016).

According to Zvobgo, missionaries regarded the ministry of the church as threefold; preaching, teaching and healing (1986:109). When the missionaries began work in Mashonaland, they used the three approaches; however, teaching and healing were embraced in preaching given that the gospel was used as a tool to pacify Africans (Zvobgo 1991). Education and healing therefore became the dual approaches to evangelise the locals. The two evangelical tools led the missionaries to build mission stations (Mujinga 2017:119-120). When the missionaries started their mission, people accepted religion not because of

²⁹ Zimbabwe is divided into major ethnic groups, namely the Shona who occupy six provinces of Mashonaland and the Ndebele who cover four provinces in Matabeleland in Zimbabwe today. Zvobgo (1991:24-60) discussed at length how Methodism was planted in Mashonaland and in Matabeleland.

what the missionaries said about God, but because of the good works that they did in the name of God. This work included the establishment of mission stations with education and healthcare facilities (Zvobgo 1991:63). As for education, the missionaries brought the African evangelists³⁰, who were black people from South Africa (Linden and Weller 1984:81-84), to help fast track their work through facilitating cultural acceptance and assimilation. Makoti (2012:120) argues that the reason for using black Africans was to overcome the barriers and difficulties that the missionaries faced as foreigners. One of the barriers was how to negotiate the culture of the local people (see also Hewitt 2012).

The Methodists mission stations that were established served as settlements of Christian examples to the rest of the pagan world (Manyoba 1991:66). Initially, everyone would want to live on the mission station. Only those residents who were committed to abide by the difficult regulations of the mission were allowed to settle, and some of those who remained did that for the sake of their children who could have access to education and medical facilities (:66), nevertheless they were not prepared to be uprooted from their culture and religion (:66). Although evangelization through education was such an important tool for missionaries, the scope of this study does not allow much attention to be devoted to it.³¹ The following section gives more attention to healthcare, which was divided into medical healing and spiritual rites healing. The focus is on medical healing, and three institutions, namely, Kwenda Hospital, Waddilove Hospital and Epworth Clinic, will be discussed as examples. In order to understand the development of healing ministry in the above institutions, the missionary approaches to healthcare systems will be discussed briefly.

3.3 Medical Care Mission in Zimbabwe

Christian missionaries started medical missions in Zimbabwe, as elsewhere in many parts of Africa, for two reasons. First, because the ministry of healing was an integral part of the ministry of Jesus. Second, missionaries viewed medical missions as an invaluable evangelistic agent (Zvobgo 1996:202). Roome (1927:18-19) acknowledges that the missionaries really knew what kind of healing the Africans needed but decided to act contrary to the mission:

³⁰ According to Thorpe (1951:54), the Evangelists were Basuto, Mustualo, Modumedi Moleli, Samuel Tutani, Wellington Belesi, Mutyuali, Mulau, Fakosi, James Anta and Shuku (see also Findland 1905:139; Zvobgo 1991:10; Banana 1991:229; Makoti 2012).

³¹ For a detailed discussion of evangelism and education see Zvobgo (1991) and Samudzimu (1991).

Missionaries regarded Africans as animist. Every act, thought and influence of their life is connected to the evil spirits. An African is not a free agent. Malign influences are ever seeking his destruction. Every sound in the forest has a subtle meaning to an African. Every force in nature touches deep-seated questions in the soul of an African. Animism and fetishism makes an African a prey to every form of unscrupulous agent. Those may be his fellow beings or the forces around him. He readily becomes a victim of the witchdoctor or the diviner (1927:18-19).

Instead of introducing healing ministry to deliver Africans from these influences, the missionaries built medical missions (2015:39). At some mission stations where a trained doctor was not available, some missionaries attended to the healing needs of the people as unqualified doctors (Zvobgo 1996:109). The people that sought healing were also introduced to the missionary platform to be evangelized. Second, Madhiba (2000:22) contends that, like education, health services were viewed as part of the enlightenment programme of human progress. Third, African traditional healing methods were regarded as intolerable to the missionaries. Thus, they regarded medical missions as a means of weaning the local people from magic witchcraft, superstition and ancestral worship (Peaden 1970:16). Fourth, the healthcare methods and practices of the Africans were seen as primitive and unhygienic, thus medical missions were regarded as a way to solve this unhygienic means of healing (Madhiba 2000: 22). Fifth, the local people were told not to invite or visit traditional healers when they fell ill since medical missions³² were an alternative to their ill health problems (:22). These perspectives serves as the justifiable reasons used by the missionaries for the construction of the mission hospitals in Africa and Zimbabwe in particular.

In Madhiba's assumptions, medical missions came as counter to the African well-established network of medical care (:22). He adds that the establishment of medical missions robbed Africans of their precious belief in their own indigenous methods of healing. Africans were at home with their cultural shaped belief system that regarded all sicknesses and death as having some spiritual causes (Shoko 2007:60). However, for the missionaries, this worldview was supposed to be removed from the minds of the Africans (Madhiba 2000:22). The process of removing this understanding had both missional and

³² According to Webster (2013:29), missions brought not only churches, but also schools, hospitals, and colleges. Missionaries reinforced the culture and power structure of the empire. They not only converted colonised people to Christianity, but also to western culture. David Livingstone is a good example of the British imperialist that underpinned the idea that commerce and Christianity cannot be separated. With the death of David Livingstone, there were calls for Africa to open for three Cs, commerce, Christianity and civilization, but the scramble for Africa became dominated by the fourth C, conquest (Webster 2013 :29),

cultural implications. The superior Euro-centric colonial and missionary culture was supposed to outdo African culture for Africans to receive the Christian gospel. Medical missions were also important institutional instruments that were strategic in advancing the civilizing and evangelizing agenda of the local people (Madhiba 2000:22).

The medical services that the missionaries offered were expected to validate their superiority to the inferior and evil practices of traditional African medicine. In whatever place they visited and offered medical assistance, they would give remarks that re-enforce the superiority of missionary medicine (Zvobgo 1991:78). For example, in 1902, Rev John White³³ recognized the importance of medical missions when he toured the Zambezi Valley by giving the local inhabitants medicine to win their confidence in the healing ministry (1991:78).

Another missionary in Zimbabwe, H. Oswald Brigg, in 1909 wrote that:

This work is not only necessary for the sake of those who have no one but the missionary to help them, but it is necessary for this reason also that until we change the native's idea of medicine we can never make him a real Christian. Half his heathenism is summed up in that one word, 'medicine'. So every case we are sure and every pain we stayed without magic, means not only relief to the sufferer, but the most powerful sermon against witchcraft and superstition as well (Zvobgo 1991:79).

In addition, Dr. L.G Parson, a Methodist Medical Missionary, argued that medical missions constituted an excellent object lesson in Christianity because a successful treatment of a sick native will influence the local people to be more receptive to the gospel (Zvobgo 1991:77).

Another missionary, the Rev Alfred S. Sharp, recognized the importance of medical missions when he and a fellow missionary visited a mission station in Mashonaland in 1911. He stated that:

My fellow traveller had won a great reputation in the land as a skilled dentist. On our arrival, we found some twenty women waiting for him, desiring assistance... so they were requested to kneel in a row before the little mission house, and my friend went from the beginning of the row to the end, dealing as carefully as a dentist can

³³ According to Thorpe (1951:58), Rev John White was one of the most dominating figure in the story of Southern Rhodesian Methodism. He was a courageous leader, a fearless prophet, and a wise and far seeing administrator. The visionary leadership of White is seen in his taking initiative to be the first to translate the New Testament into the local language. White was also the founder and builder of Waddilove Institute, which is one of the most prestigious Methodist Schools in Zimbabwe. In addition, he served as the Southern Rhodesian District Chairman for twenty-five years which was the longest period (from 1901 to 1926) of the forty years he worked in Southern Rhodesia (Kadenge 1991:112).

with each one of them. When the last refractory tooth was in the hand of the grateful patient, I suggested that we should sing the doxology. This could not be done, but every patient went away shortly afterwards. We commenced our service in the little house on the mission station (Zvobgo 1991:79).

Although the testimonies by Parson, Briggs and Sharp seem to confirm that Africans valued western forms of healing and western medication, since the voice of Africans themselves are not heard in their narrative, their report should best be treated with the hermeneutics of suspicion. However, the respect and appreciation for European medical treatment was evident in the political support given to these institutions. The fact that some patients were able to sing just after a tooth extraction from the western dentist attests to their appreciation for being relieved from great pain. After opening a dispensary at Tegwani in July 1918, Brigg wrote:

The surgery is in the open, the drugs and equipment are of the simplest kind, but the cures wrought are marvellous - at any rate, in the eyes of the Africans. When a wound that has been festering for weeks, or perhaps for months, when every native remedy has been tried and has failed - and they make their journey to the nearest mission station, and then after thorough washing and treatment, it begins to heal, they are greatly amazed, and what is better, generally very grateful (Zvobgo 1991:83).

The choice of embracing the missionary medical services was usually made after the failure of traditional doctors and their medicine. However, the African embracing of missionary medicine should not be interpreted as a rejection of their traditional medicine. They embraced both and their medical need determined the choice of medical care.

In the region of Zambia, the importance of medical missions was recognized by Dr. Walter Fisher of the Plymouth Brethren who argued that the only way to wean an African from superstition and the worship of the ancestors and eventually bring about lasting conversion was by demonstrating the power of the white man's medicine (1991:77). The different statements above demonstrate that although medical missions were essentials for Africans' health, the missionaries used them as a strategic evangelisation tool to expand church growth. The Methodists building of their first mission hospital in Zimbabwe in 1913 (1991:79) was to serve as the church's evangelisation goals. According to Lartey et al (1994:297), "modern western medicine was effective in providing answers to different ailments and their healing methods based on the observable and tangible etiological factors". This point supports the birth of Kwenda mission hospital in 1913, Waddilove

Nurse's Training in 1927, and clinics at Chemhanza, Thekwane and Epworth. Kwenda, Waddilove and Epworth will be discussed in this research because Kwenda forms the first attempt of the church to develop its healing ministry through medical care, which eventually leads to the missio-cultural confrontation of western and African methods of healing.

3.3.1 The First Medical Mission at Kwenda

Zvobgo states that “Wesleyan Methodist began their medical work among Africans in colonial Zimbabwe when they opened their first hospital at Kwenda Mission³⁴ in 1913” (Zvobgo 1991:13, 76). However, it is worth appreciating that Methodists were not the first to establish the mission hospital. In his 1986, work, Zvobgo reiterates that the

American Congregational Church, opened a dispensary at Mount Selinda in 1893 and Chikore mission in 1900. The dispensary at Mount Selinda was gradually expanded until it became a full-fledged hospital. In the Victoria Province (now Masvingo), Christian medical missions were pioneered by missionaries of the Dutch Reformed Church at Morgenster mission, in 1894 and Chikarudzo on Morgenster mission farm in 1899. In July 1914, the Government approved the appointment of Dr Helm as Medical Superintendent of the Leper Settlement at Morgenster (Zvobgo 1986:109-110).

If one goes by Zvobgo's assertions, it is evident that the Wesleyan Methodist missionaries joined an ongoing medical mission work. However, in spite of this history of missionary medical care in Zimbabwe, it is only the MCZ among the historic mission churches that does not have a medical hospital. These contributions by Zvobgo set a stage to examine the medical work at Kwenda hospital and to identify its shortcomings.

The Government offered resources towards the construction of Kwenda Mission hospital in part from paying the medical doctor (Zvobgo 1986:113, 1991:13). In addition, the “Government also contributed to the cost of drugs and other surgical instruments and general equipment” (Zvobgo 1991:13). “Dr. Sidney Osborn arrived at Kwenda Mission in May 1913 and the hospital, which accommodated 18 inpatients, opened its door the same

³⁴ Kwenda Mission is one of the products of colonization, partitioning and evangelization of Africa and accepting western Christianity (Mujinga 2011:47). The mission is one of the eight mission stations of the MCZ namely Epworth mission, Chemhanza, Waddilove, Moleli, Thekwane, Pakame, and Sandringham (Mujinga 2011:47). Most of these mission stations had missionary medical centres. However, today only Epworth, Sandringham and Pakame still have clinics. Kwenda will be very important in this research because the Africans who resisted the missionary medical healings, like Mai Chaza, Paul Mwazha and Loveless Manhango, all come from Kwenda area.

year (Zvobgo 1991:13). “By December 1913, 128 patients had been treated at the hospital” (Zvobgo 1991:13). According to Thorpe, the Methodist Missionary Committee of 1914 made reference to the opening of the hospital saying it was given a satisfactory report. He adds that the Missionary Committee was most thankful to have been enabled by the generosity of the government to found the first hospital in the South Central Africa. The Missionary Committee adds that, “we hope to be the forerunner of others. In Dr. Sidney Osborn, you have a man of the right type and the right spirit” (Thorpe 1951:80). This statement does not assume that the Methodists were the first to build a medical hospital, as argued earlier, but first in the specific area of Kwenda. So although the Methodist Church does not own or operate a hospital in the context of contemporary Zimbabwe, it was however the first church to establish one in Kwenda area.

Dr Osborn experienced a number of challenges at Kwenda Hospital in 1913. First, it was due to the procrastination of the Shona people. Either from a distrust of the white doctor or their fear of life, however, they come to the hospital with their troubles, and expects to get immediate cure from the first dose of medicine we administer. If this does not happen, the patient frequently goes back home disappointed and firmly convinced that we are not good as doctors (Zvobgo 1991:81). The second challenge is to make patients and their friends realize that if any benefit is to accrue from the treatment they are undergoing, they must obey implicitly the doctor’s instructions (1991:81).

A key challenge encountered at Kwenda Hospital was the difficulty “to break down the natives prejudices against hospitals” (Gondongwe 2011:64). In spite of all the necessary support rendered by the government, Kwenda Hospital was never a success story to the Methodist missionaries. However, the services of the missionaries in the medical fraternity remained pivotal. For example, Zvobgo holds that when the influenza epidemic swept Zimbabwe in 1918, the government requested Revds. G.H.B. Sketchely and J.H. Loveless to assist in preventing it from spreading among the people (Zvobgo 1991:81; Sketchely 1919:135-6). The missionaries obtained medicine from Salisbury³⁵ and with the assistance of the African Evangelist (see footnote 35), they managed to control the epidemic at Epworth Clinic. What was sad about the influenza, as observed by Zvobgo, was that although the missionaries tried their level best through the assistance of the government, the

³⁵ Salisbury was the colonial name for Harare, now the capital city of Zimbabwe. The name Harare will be used but where history has to be emphasized, Salisbury will be used.

disease had a negative impact on the church (Zvobgo 1991:81). Sketchely visited Methodist missions, dispensing medicine. He proceeded to Marshal Hartley mission; when he arrived, he found Rev Josiah Ramushu, one of the native ministers, in a dying condition because of the influenza. He did all that he could to save him but Rev Ramushu died shortly afterwards. Sketchely remarked that the death of Rev Josiah Ramushu³⁶ was a great loss to the Methodist Church (Zvobgo 1991:81).

3.3.2 The Demise of Kwenda Mission Hospital

Whereas Kwenda hospital struggled to get momentum and attract the locals, other missionary hospitals progressed well. A few examples as observed by Zvobgo will justify this assertion. Mnene Hospital of the Church of Sweden (now Evangelical Lutheran Church in Zimbabwe) in Belingwe (Mberengwa) treated 1,355 outpatients in 1930, and 66 cases of leprosy (Zvobgo 1986:117). Mount Selinda of the American Congregational Church (now United Congregational Church of Zimbabwe) had 858 inpatients, 1,689 outpatients and 57 operations by 1936 (:111). In addition, Morgenster Hospital of the Dutch Reformed Church had 24 beds, 1,386 in-patients, and 4,137 outpatients with 36 operations by 1935 (1986:112). Kwenda Hospital only survived for three years. According to Gondongwe (2011:63), a few patients occasionally visited the hospital but sometimes there was no patient the whole day. In view of this situation, the doctor used one of the largest wards as a day school for children (Gondongwe 2011:63; Zvobgo 1991:80; Banana 1991:13). By June 1916, there was no change and the government withdrew the resources. Dr. and Mrs. Osborn terminated their services at Kwenda Hospital in March 1917 and left the country for Britain” (Zvobgo 1991:80). In 1916, Osborn wrote expressing his discouragement on the

³⁶ Rev Josiah Ramushu was one of the teacher-evangelists who had come to Zimbabwe with Isaac Shimmin and Owen Watkins from Transvaal. According to Thorpe (1951:54), the other Evangelists were Basuto, Mustualo, Modumedi Moleli, Samuel Tutani, Wellington Belesi, Mutyuali, Mulau, Fakosi, James Anta and Shuku (see also Findland 1905:139; Zvobgo 1991:10; Banana 1991:229; Makoti 2012). Gondongwe (2011:91, 307) adds that Ramushu was the first Black Minister to be ordained in 1910 in the Wesleyan Methodist Church and he died in 1918 (Banana 1991:23). Modumedi Moleli and James Anta were killed during the Mashona Rebellion of 1896. The other five returned back to South Africa but Ramushu, Belesi and Tutani stayed and made Southern Rhodesia their home. Ramushu and his three sons, Oswald D. Ramushu (1943 to 1990), Willie J. Ramushu (1937 to 1979) and David Ramushu were Methodist Ministers (Thorpe 1951:58; Banana 1991:223). David Ramushu is one of the ministers who established Methodism in Zambia. What made Ramushu’s death a loss to the Methodist Church, as argued by Zvobgo (1991), was that he was a trusted minister by the missionaries (see Gondongwe 2011). Rev John White states that, ‘we trusted Ramushu because he was a good man and he loved us’ (Gondongwe 2011). He started a church service in Epworth and gathered around him many children. One of the Sunday Scholars at Chiremba confirmed that Ramushu was a great man (Gondongwe 2011).

medical field caused by the failure by the locals to break down the natives' prejudice against hospitals" (Gondongwe 2011:64; see also Zvobgo 1986:114).

Banana and Zvobgo concur that Dr. Osborn and his wife were forbidden to remain in Rhodesia on medical grounds (Zvobgo 1991:80; Banana 1991:13). Although the professional medical doctor had left Kwenda, in the spirit of John Wesley who offered drugs to his members, the missionaries continued to give medical services as best as they could (Zvobgo 1991:80; Banana 1991:13). What remains unclear was whether the missionaries who continued with the healing ministry had knowledge to engage in medical care and the administration of medicine. What remains clear, however, is that medical work continued, and between April and September 1917, over five out-patients and three in-patients were treated (Zvobgo 1991:82).

In spite of this promising future of the hospital, it finally closed its doors in 1917 (1991:80). According to Thorpe, the Methodist Missionary Committee wrote a laconic paragraph in their letter of November 30th, 1917 to the people of Kwenda apologizing for the unceremonial departure of Dr. Osborn. Part of the letter reads: "We are very sorry that during the year, you have lost Dr. S. Osborn. Of course, as the government withdrew its grant to Kwenda, the closing of the hospital was inevitable (1951:80). From the contents of the letter it is evident that the Methodist missionaries had no capacity or intention to run the hospital but were depending upon the government. This is not surprising, using the words of Parratt in reference to the shortcomings of Christianity. He argues that:

While western missionary Christianity was deeply important, however, it was felt that the form in which it has been presented had failed to penetrate to the heart of the African personality, one reason being that Christianity was introduced in Africa during the colonial era, as such, religion prospered largely because it had been supported by the ruling European imperialism (1997:6)

Thorpe concludes that Southern Rhodesian Methodist District lost a fine man and the beginning of fine work. The little hospital served as a carpenters' shop (1951:80). In the 1920s, people who mostly visited western hospitals were those who resided on mission farms; according to the laws promulgated by the missionaries, they were those who were obliged to do so (Gondongwe 2011:64). People who came outside the mission farms would not visit the hospital until their disease had become chronic and any hopes for life had been dashed (2011:64). For Madhiba, the abandoning of the hospitals could probably be that the

local people did not trust the expatriate's medicine or that traditional healers warned people against using the White man's medicine (2000:23).

An analysis of the developments that led to the closure of Kwenda Hospital steered Gondongwe to interview his grandfather, who complained that, during those years, African people did not want to seek medical attention from the western institutions (Gondongwe 2011:64). In his investigations, Gondongwe observed that many Africans believe that witchcraft, the living dead or the avenging spirit were the causes of the diseases (2011:64; see also Shoko 2007). This remains a challenge even today. The efficacy of the western medicine was doubted on the grounds that it was believed to concentrate on the symptoms of the disease, leaving out the metaphysical causes (2011:64). Oosthuizen *et al* (1988:15) summarize the major difference between the two types of medicines by citing that modern medicine is based on the imperial specialized biomedical model of natural science whereas traditional and alternative approaches to medicine are often both natural and supernaturally oriented on the symptoms of the disease, leaving out the metaphysical causes. For the missionaries, only an instrument like the thermometer would determine that one is ill. Oosthuizen *et al* (1988:15) further argue that "for most Africans, illness is caused or ascribed to a disturbance of balance between humanity and spiritual or mystical forces and the aim of health is seeking to restore the equilibrium" (see also Shoko 2007). In the case of the Kwenda situation, this was not to be.

Madhiba (2000:23) also thinks that the problems that led to the closure of Kwenda hospital revealed a lack of calculation and misjudgement of African medical need by the expatriates. They medicalized healing which, for the Africans, was not the solution. The contribution of Lartey *et al* in a Nigerian context presents a replica of the attitude of the missionaries towards Africans. The three scholars argued that, with some few exceptions, missionary spirituality was characterized by varying degrees of intolerance and aggressiveness; as such, it was not easy to win the hearts of the Africans (1994:17). Apart from the approach used by the missionaries to introduce healing ministry, the economic factor cannot also be ruled out. The mission had to depend on government subsidy for the hospital and apart from providing personnel, it took significant resources to run a hospital. Therefore it raises questions about the financial commitment of the Methodist Mission to the medical venture. The failed attempt at Kwenda hospital did not dishearten the Methodist missionaries. Ten years later, another attempt was made at Waddilove Institute. The failure of Kwenda mission

hospital can be concluded to be a missio-cultural deadlock between the missionaries with the mission and the locals who were grounded in their cultural beliefs.

3.3.3 The Second Missionary Medical Mission at Waddilove Institute

The setback at Kwenda hospital did not make the Methodists abandon the healing ministry (Gondongwe 2011:64). In May 1927, they opened another healing centre at Waddilove Institute (Zvobgo 1986:114). This centre was later to be used as the training institute for African nurses. Sister Madge Dry came from England specifically to be the instructor at this centre as an employee of the Methodist Society in Rhodesia (Thorpe 1951:80-1). When she arrived, there was no infrastructure suitable for the task and her bedroom was the ward for over a year, where she did nursing herself (Banana 1991:14; Gondongwe 2011:64). During the same year, the Synod requested a grant from the Missionary Committee in London to be sent for the building of a small dispensary and a hospital at Waddilove (Zvobgo 1986:114). What came out clear was that, although the project appeared to be big, the locals were to raise £300 for this project (Gondongwe 2011:64; Banana 1991:15). Mr Harry Clay built the medical male centre in honour of John White³⁷ (Thorpe 1951:81). The aim of the hospital was not only for the treatment of the sick, of the institution, and of the neighbouring reserve, but also for training African nurses (1951:81). The Missionary Committee agreed to the request and the hospital was opened on the 27th of November 1927 (Gondongwe 2011: 65). The opening of the Waddilove Hospital enabled Sister Dry to treat patients who could not get to the District Surgeon (Banana 1991:14).

In 1928, four student nurses, Ester Maketo, Barbara Benn, Dinah Mgugu and Lillian Tyeza, began to train as nurses and by the end of the year they had graduated (Zvobgo 1986:115). The nursing examinations were conducted by Dr. T.G. Burnett of the Bulawayo General Hospital. Burnett remarked that the result of the success of the examination was due to the hard work of Sister Dry (Banana 1991:15). In 1929, Sister Dry sent the Medical Director a detailed syllabus of the three-year training course in nursing at Waddilove Hospital (Banana 1991:15). At the end of the year, five student nurses sat for their examination, which was conducted by Miss Reess, Matron-in-Chief of the Southern Rhodesia Nursing Services, and they all passed (1991:15). Miss Reess wrote that: ‘the girls’ showed great interests and

³⁷ The Institution was later rename Waddilove in honour of Mr Josiah (later Sir) Waddilove who donated £2 700 in total for the as a donation towards the completion of the building projects in 1915 (Thorpe 1951:81).

enthusiasm. The practical work was of very good standard (Banana 1991:15). In spite of all the good efforts and brilliant ideas to develop Waddilove Hospital into a fully-fledged medial institution, the government did not recognise Waddilove Hospital as a training school for orderlies and nurses (Banana 1991:15). According to Methodist scholars like Gondongwe, first, it was because there was no medical practitioner attached to the hospital. Second, the hospital was very small and treated only a limited range of diseases so that it could not, in the opinion of the government, provide efficient and comprehensive training (2011).

Banana highlighted that in spite of the failure to get recognition as a training school for African nurses, medical facilities were expanded at Waddilove hospital (1991:16). In 1933, Rev John White donated £1000 for the extension of the work (Gondongwe: 2011:65). He is counted among the missionaries who saw the need for mission and culture to converse and he also identified with the Shona people who called him *Baba* (father). White's closeness to the African people and their culture made him unpopular with the fellow missionaries (Kadenge 1991). However, Mpagi (2002) confirmed that White was not an exception because many missionaries also sought to inculturate the gospel. These missionaries learnt the African languages and translated scriptures into vernacular language; White translated the book of Mark into Shona and later the entire New Testament (Thorpe 1951:58). In 1937, the Southern Rhodesia Synod decided to proceed with Memorial Hospital at Waddilove as a men's ward and allocated £700 towards its development (Banana 1991:16). In 1939, the John White Memorial Hospital consisting of a women's ward, maternity ward, a labour ward and a paediatric ward (babies' nursery) was officially opened (1991:16). The hospital continued to operate until 1964, when it was closed down and nurses in training were sent to Howard Institute, which belonged to the Salvation Army (1991:16). According to Gondongwe, since that time the Wesleyan Methodist Church has not returned to the healing ministry through hospitals while other denominations did well in this area (2011:66). However, the church continued with medical work at clinics and a case in point is Epworth clinic which will be discussed later. Therefore Gondongwe's statement can only be confirmed when he is talking about large scale medical services, but otherwise the claim is misplaced. The factors that led to the discontinuity of Waddilove hospital are worth pursuing.

The first critical point to note is that in spite of Sister Dry's long service at Waddilove hospital for 37 years, from 1927-1964, neither the Methodist Society in Rhodesia nor did the Methodist Missionary Society took a deliberate move to replace her as the nursing instructor. Since Waddilove had expanded to become a hospital, the missionaries reluctantly identified someone with even a lower qualification to maintain the health institution. On one hand, the challenge was exacerbated by Dry's poor training of health personnel that saw Africans failing to take over from her. On the other, the locals were reluctant to take such a challenging job (Mujinga 2012:15). The second reason could be the lack of succession plan by the missionaries. Third, the church had not taken ownership of the project fully, and as such, the retirement of Sister Dry marked the end of church's burden. This attitude can be seen as similar to the situation of Kwenda Hospital which did not receive a replacement after Dr Osborn left in 1913. Fourth, it seems the institution had become a big cost centre and since the government was sponsoring it, it could not continue and the church was not prepared to take over the financial obligation. Such challenges necessitated the Methodist Church to operate health institutions at a smaller scale. Of all the challenges discussed above, the worst action taken by the Methodist Church was sending their nurses to be trained by the Salvation Army related institution. This alone was a strong statement to end healing ministry.

3.3.4 Epworth Mission Clinic

The inability to plan ahead for leadership change in hospitals, the inability to generate sufficient financial support for the hospitals, the failure to enter into practical partnership with government and or other ecumenical bodies to manage the hospitals, and the failure to involve local Africans in owning, operating and supporting the hospitals as argued earlier had a negative impact on Waddilove hospital that led to its closure. In 1964, medical missions were phased out of the Methodist Missionary work (Madhiba 2000:45). These above four weaknesses demonstrate the level of unpreparedness and unwillingness by the Methodist Church to embark on medical mission at a large scale. It can further be argued that the experiences of Dr. Osborn at Kwenda had weakened support for medical missions overseas; however the development of other medical institutions in other churches between 1916 and 1964 does not validate that assumption. Madhiba argues that Methodist medical missions came to a tragic end because there were no local people who were trained as doctors to take over from the expatriates (2000:45). Since the country was governed by the

British colonizers, their failure to prevent the unceremonial closure of Kwenda and Waddilove indicated the low value in which they viewed the project. Their failure also to seek understanding rather than dismissing and condemning African indigenous methods of healing meant that the Methodist medical mission functioned in hostility to the culture of the local people without seeking for lasting solutions of accommodation. The core reasons for the Methodist Church's reluctance to develop sustainable medical centres in Zimbabwe requires further in-depth research but that is not part of the objective of this study.

Epworth Clinic opened its doors as a dispensary during the early years of Methodism in Zimbabwe (Maruva³⁸ 2016). In the 1960s, the clinic was operating in a very small thatched house as a dispensary (2016). In 1970, the dispensary was closed because of the liberation struggle, which was very unstable in Epworth. Epworth was one of the politically volatile places (2016; Dende³⁹ 2016). Besides the political challenges, the community was obliged to pay the nurse who was operating the dispensary since the pharmacy belonged to the mission. Unfortunately, the community could not raise the salary for the nurse through medical services and the nurse locked the dispensary and left. The dispensary reopened in 1978 as a clinic with Mrs. Nestai Maruva who had trained as a nurse in 1958 as its first African nurse. Maruva worked in Karoi and Chinhoyi⁴⁰ clinics but her contract was terminated when she became pregnant and returned home in 1977. She went to work at Rusike clinic east of Harare, which also closed in 1978 because of the war of liberation (Marufu 2016). Mrs. Maruva requested to open the clinic from the management committee because the local people had to travel to Hatfield, which is approximately ten kilometres from Epworth, on foot because of lack of public transport. Besides, most private transportation were owned by the white population who were not read transport the black people because they were considered to be inferior (2016).

Epworth Circuit was under Rev Oswald Ramushu, one of the sons of the first Africans to be ordained as a Methodist minister (see footnote 35). Rev Ramushu played a pivotal role

³⁸ Netsai Maruva was interviewed on 29 August 2016 since she was the first nurse to operate at Epworth Clinic. The records for the clinic were burnt and it was not easy to get records. The Methodist Archives and Epworth Circuit offices were visited but no records could be found. It is against this background that Mrs Maruva became the main source of the Epworth Clinic supported by the Sister in Charge – St Tamari Dende. In addition, most of the people who contributed to the Epworth Clinic are now late.

³⁹ Tamari Dende has served as a Nurse at Epworth Clinic for 15 years and as a Sister in Charge for the clinic for six years now.

⁴⁰ Karoi and Chinhoyi are in Mashonaland West Province, north-west of Harare going towards Zambia.

in the reopening of the clinic that included the payment of the salary of the nurse (2016). The work later received additional assistance of nurses and medication support (2016). In 1994, the Methodist Church in Zimbabwe received a donation towards health facilities and channelled the resources to Epworth Clinic for expansion of the health institution (2016). Maternity wards were also constructed. The government also intervened with resources for the payment of the nurse. This action led the clinic to be put under Seke Rural District Council, which also operated in partnership with Zimbabwe Church-related Hospitals Organizations (ZCHO).

The government further decided to build a clinic at Domboramwari, which became a competitor to Epworth Clinic (Marufu 2016). The opening of Local Government clinic at Domboramwari, some 5km from Epworth clinic, led to the closure of the maternity ward (2016). The Methodist Church appointed a clerk to manage the finances of the clinic because of its potential to attract more than thirty outpatients daily. The clinic increased to eighty (80) people a day and more than one thousand five hundred (1500) patients a month that included both Methodist and the non-Methodist people from the community (Dende 2016). The clinic has a staff of seven General Nurses, four Primary Care Nurses, three Nurse Aids, one Environmental Health Technician, one Clerk, two Security Guards and one groundsman which is a total of nineteen employees (Dende 2016) and covers the catchment area of Overspill, Domboramwari⁴¹ and Glenwood.

Healing ministry at Epworth society is divided into religious and medical. However, the elders in Epworth have not demonstrated interest in the way healing ministry is conducted in the church and at the clinic. This dichotomy in approaches to healthcare by the church reveals a schizophrenic and un-holistic approach to the wellbeing of people. Mrs. Maruva, the church's representative at the clinic, for example, has compartmentalised medical care from the healing ministry of the church and fails to identify their inter-connectivity. Epworth clinic now accommodates large volumes of patients because of many illegal settlements. The church contributes to both the medical and spiritual life of the people in Epworth community, by preaching to them and providing medical facilities; however the ministry is

⁴¹ There are Local Government clinics at Domboramwari (the stone of God) which is five kilometres from Epworth Mission Clinic, and Overspill, about the same distance in the opposite direction, which have the same charges with Epworth Mission clinic, however, people prefer Epworth Mission because it is a Church clinic. Besides, people in Epworth are mobile and as such, Epworth becomes the most preferred clinic because it is a mission clinic and also the reception is expected to be good.

strategically disconnected and does not intentionally relate to each other. MCZ today has small clinics at some of its mission schools like Pakame, Sandringham and Kwenda (Tanyanyiwa⁴² 2011).

3.4 Challenges that Affected the Development of Healing Ministry among the Missionaries

There are a number of challenges that affected the development of the healing ministry among the Methodist missionaries. First, John Wesley believed that people must be taught basic ways of healthy living as well as simple forms of fighting disease and this could have influenced the Wesleyan Methodist Missionary Society. However it could be argued that they failed to prioritise healing ministry. Second, the Wesleyan Methodist Missionary Society had no deliberate policy to train its clergy in other professions beside the ministry of dispensing the Word and Sacrament. This was evidenced when Sister Dry retired in 1964, having worked from 1927; there were no succession plans for her replacement with another qualified missionary. Third, the missionaries, as we will discuss in the next chapter, did not quietly take time to understand the African culture before they introduced their missionary practices. This situation erupted into a missio-cultural conflict. Fourth, healing ministry in Europe at the time that the missionaries went to Zimbabwe had been influenced by the spirit of enlightenment. As such, they discarded other non-European worldviews and cultures such as the African understanding of healing. Parratt argues that the tendency of missionary Christianity to devalue traditional African cultures, especially to dismiss religion as heathen or pagan, had a negative bearing in their mission (1997:4) It is not surprising therefore that the same syndrome has been received by the African ministers – to shun away their culture – which has caused some members in the MCZ to have dual membership. According to Moyo:

Many traditional religions continue to exert tremendous influence over the majority of people in Zimbabwe. Even those who have become Christians continue with traditional religions because during the colonial era religion and culture were heavily suppressed by both missionaries and colonial administrators. Missions were used as platforms from which to proselytize and destroy African cultures and people's identity. The result was that many nominal conversions to Christianity occurred but those same people practiced their traditional beliefs on the ground (Moyo 1987:62).

⁴² Tichapiwa Elton Tanyanyiwa was the Health and Social Services Coordinator with the Methodist Church who resigned in 2012.

Moyo concludes by arguing that the majority of the people of Zimbabwe practice some form of traditional religion or a combination of traditional religion and Christianity (1987:62). This dual embracement has also entered into the healing ministry where Methodist members will go wherever they know their healing needs can be met.

3.5 Conclusion

This chapter has discussed the challenges faced by the Methodist movement after the death of John Wesley and the development of Methodism within Zimbabwe. It argued that the enlightenment perspectives had affected the understanding of Christianity, which led the missionaries to transport a secularized mode of evangelical Christianity into Africa. The Wesleyan Methodist Missionary Society expanded from South Africa into Mashonaland latter known as Rhodesia. Cecil Rhodes, an influential British colonialist, and the colonial government supported the establishment of Kwenda Mission Hospital. In spite of the efforts by the missionaries with their modernized western healing methods, their work at Kwenda and Waddilove Institute was not sustainable and had to close (Zvobgo 1996:202). The Church's failure to take seriously the local people's understanding and practice of healing contributed to their ill-fated medical agenda that was not in partnership with the people who were objectified rather than treated as subjects. The church's condemnation of African indigenous healing rites, without offering solutions to the African understanding of health ministry, led to the missio-cultural confrontation, dislocation and dissonance with the local culture. These developments will be discussed in the next chapter with a focus on three Africans who were excommunicated from the Methodist Church and formed their own African Initiated Churches (AICs).

CHAPTER FOUR

THE CONFLICT BETWEEN METHODIST MISSIONARY MEDICAL HEALING AND TRADITIONAL AFRICAN HEALING METHODS

4.1 Introduction

The previous chapter has discussed the challenges faced by Methodist movement after the death of John Wesley that includes enlightenment and its philosophy of deism. The chapter has also deliberated on the development of Methodism in Zimbabwe and its accompanying education and medical healing mission. The chapter also examined the missionaries approach to healing ministry and the weaknesses that limited its impact among the local people. These clash of European religio-cultural worldview with the local African worldview led to ideological conflict between missionaries and indigenous people. This resulted in cultural alienation that contributed to the formation of three African Initiated Churches (AICs) within Zimbabwe emanating from the Methodist Church namely Guta Ra Jehovah led by Mai Chaza, African Apostolic Church founded by Paul Mwazha and Bethsaida Apostolic Church led by Loveless Manhango. These three leaders were caught between Methodist form of healing which was offered and taught by the missionaries and the African forms of healing since they were African-Methodists. In order to appreciate the two healing influences, healing in the African perspective will be discussed first.

4.2 Healing in the African Traditional Religions⁴³

⁴³ I am aware that there are scholarly debates going on as to the actual term to use. A number of African scholars like Mbiti (2000) and Mndende (2015) still use the term African Traditional Religion (ATR). Although Mwandayi (2011) feels that ATR is very difficult to define, stating that there is no single, simple and precise definition prescribed to ATR, according to Mndende (2015:16), ATR means the indigenous religion of Africa South of the Sahara. The religion was born in the continent and has been handed down by the forefathers from generation to generation. The religion has no founder, and is divinely revealed to its practioners (Mndende 2015:16). Nevertheless, progressive scholarship is condemning the term traditional as they assimilate it with old fashion and archaic. These scholars include Chitando and Klagba (2013) who suggests terms like African Religion(s) (AR) or African Initiated Religions (AIR). In one of their writings, Chitando, Gunda and Kügler (2014:183) take the debate further to include Christianity and Islam as African religions. Mndende thinks that traditional, however, is just a pointer to the religion as bred in African soil more than anything else. The research will adopt ATR to distinguish it from what Chitando, Gunda and Kügler would define as AR including Christianity and Islam” (2014:183). The research has also taken a historical approach, especially the missionary era language. It therefore makes sense for the researcher to argue historical facts in their context (see also Nurnberger 2007:16).

4.2.1 Traditional Understanding of Healing

African scholars who researched on healing generally agree that being well and wellbeing cannot be discussed outside the African worldview (see Shoko 2007). These scholars confirm that Africans believe in the ancestors as the supreme powers who can cause illness and restore health to the living (Gelfand 1971; Mbiti 2000; Echema 2006; Nurnberger 2007; Shoko 2007; Masaka and Makahamadze 2013; Taringa 2013; Mpanyangi 2013; Mndende 2015). Shoko (2007:58) holds that if the ancestors are not honoured through the requisite rituals, they express their anger and dissatisfaction through illness befalling the living. Scholars such as Daneel (1970), Shoko (2007), Murove (2009) and Taringa (2013) have demonstrated that illness among the Africans is caused⁴⁴, and the famous root is misfortunes⁴⁵. Echema (2006:32) notes that at the centre of sickness or death and other calamities, the reaction of the African is, “who did it and why, which of the spirits or ancestors had been wronged and what human relationship had been strained (see also Mbiti 2000:63; Murove 2009:172).

According to Lartey et al (1994:19-20), sickness among the Africans is considered as a disaster and therefore healing is a liberation of life’s negative forces (see also Shoko 2007:57-65). Lartey et al and Shoko are of the opinion that health in Africa means wholeness⁴⁶. The cultural intercourses of missionaries and the blacks created a hybrid form

⁴⁴ The causation of illness in Africa was intensively studied by a number of scholars. It might not be within the scope of this research to labour on the already over-researched areas. Among these scholars are Michael Gelfand (1971), John Mbiti (2000; 2002), and Tabona Shoko (2007). Suffice to highlight that according to Masaka and Makahamadze (2013), any Shona, in spite of his or her lifestyle, when faced with any critical illness, consults the diviner or the herbalist to learn whether there was something they could do to deal with the anger of the ancestors. This position, however has remained a claim which the researcher is reluctant to ratify.

⁴⁵ According to Shoko (2007:58), ancestors are the guarantors of an orderly society and human behaviour and any violation of an orderly society can make the ancestors angry and punish the culprits by illness or misfortunes. Misfortunes range from barrenness, miscarriage, illness, death, unemployment or poverty.

⁴⁶ Wholeness in an African setup means one is healthy, complete, uninjured or undamaged (Lartey, Nwachuku and wa Kasongo 1994:126). Wholeness for these three scholars has to do with healing the total wellbeing of a person or his/her restoration in every dimension (see also Shoko 2007; Dickinson 1995:3; Healey and Sybertz 1996:298; and Romans 8:19-24). It is probably from this understanding of wholeness that the World Health Organization (WHO) defines health as a complete state of physical, psychological, and mental wellbeing and not merely the absence of infirmity (The Preamble of the Charter of WHO Encyclopaedia Britannica vol 8.p. 68). Louw adds his voice to WHO, stating that health is often regarded as a normal and natural state. Illness then becomes abnormal and unnatural (Louw 2007:1). When we consider health, we must allow for the fact that it can be seen from various perspectives, the psychoanalytical, existential, functional, sociological, natural, scientific, medical and religio-ethical (Louw 2007:8). The above perspectives of health have a bearing on the spiritual life of individuals and the solution is faith-healing. This point is synthesized by Patte (2010:494), who however criticize WHO’s definition of health as too broad and almost equivalent to the notion of human happiness. For Patte, health is not just the absence of injury, disease or disability, but has something to do with the whole person since humanity is not just the body but is also spiritual (Patte 2010:494).

of healing. Chavhunduka (1978:14) notes that Shona people believe in the ability of certain people to harm others with charms. Although Chavhunduka was writing about the Shona ethnic group, general African scholarship confirms that this is a common African challenge (Gelfand 1971; Mbiti 2000:200; Shoko 2007). Mwaura is explicit to identify these people as the witches and wizards (2000). She argues that Africa has a number of challenges which has resulted in cultural identity. The consequences of this dislocation and disorientation in her view have become a haven for psychological disturbances which are manifested in physical illness. One of the serious cultural beliefs on which Africans glue their faith as a potential calamity is witchcraft. It is in these problems and confusions that healing is outsourced from ATR, by a large number of Protestants in general and MCZ in MEM members in particular.

Chavhunduka (1978) further claims that Protestant church members are taking their problems to traditional healers and prophets and this is a serious challenge to the church. Mndende adds that some members of the mainline churches practice their indigenous religion at home and declare themselves as Christians in public (2015:31; Leonard 2009:180). Chavhunduka expressed these syncretic behaviours openly when he complained that, “if church members say Zimbabwe National Traditional Healers Association (ZINATHA⁴⁷) is full of heathens, it offends us for we will be there for the services in Catholic, Anglican and other mainline churches. We are together, only functions differ” (Gunda 2011:143). Mndende also claims that church members believe that ancestors heal, whether at home and church. In spite of the fact that Chavhunduka and Mndende are writing as practitioners and are also insiders of the African traditional religion, their understanding presents the African worldview as a threat that Protestant church members in general and Methodist Church members in MEM in particular experience, thereby ending up

This missio-cultural study appreciates that it is a combinations of these aspects and the search for wholeness. Methodist members in Mabelreign, Mbare and Epworth see healing ministry as a basic commodity for them. Kelsey (1973) confirms this point by stating that the health of the body and mind depends upon one’s religious life.

⁴⁷ According to Mwandayi (2011:236-240), ZINATHA is an association of traditional healers in Zimbabwe. The association was formed in 1980 when Zimbabwe got her independence. The Bill of its legalization was passed by the parliament through the help of the Minister of Health. The establishment of the association raised a lot of controversy with Christians since the church felt that this was the promotion of heathenism. Mwandayi quotes Chavhunduka as praised by most clergy as maintaining ATR. He was also invited by Catholic Church to present lectures on the role of ZINATHA in the society (Mwandayi 2011) Some of their aims and objectives are to unite all traditional healers into one body, to promote traditional medicine and practice, to promote research into traditional medicines and methods of healing, to supervise the practice of medicine and prevent abuse and quackery. The membership to ZINANTHA is open to all traditional healers including spirit mediums and faith-healers (ZINATHA Constitution p. 1-8).

schizophrenic in terms of their faith. The quest to leave culture and remain a Christian, sees church members limping in two worlds, one of the African culture and the other of their church membership where healing remains a basic commodity. This is one of the major problems that the characters who are discussed in this chapter went through, and thereby left the Methodist Church.

4.2.2 African Traditional Approaches to Healing

Taringa (2013:210) argues that healing in Africa has to do with perseverance to restore human vitality in the context of the community as a whole. One of the chief functions of religion in Africa is healing physical, spiritual, and psychological diseases which affect the lives of many Africans. This understanding of sickness leads African Traditional healers to become a source of hope to the healing needs of the Africans because they offer seemingly cheaper and faster solutions to ailments (Mucherera 2001; Leonard 2009). Louw argues that illness upsets the normal programmes as well as a sense of regular routine, order, habit and security. This upset of normal programmes is sometimes characterized by failure to acquire resources for medication, thereby pushing individuals to African traditional healers. The normal human reaction is to reinstate the previous state of affairs as soon as possible. ATR provides the best and fastest solution. In this process, people try everything to gain health (2007:1). Sickness of whatever form represents a crisis in the life of a person who is ill (Louw 2007:1). In this situation, Chavhunduka's claim could be right since it addresses how the Africans struggle to balance their spirituality between the equilibrium of faith and culture.

In an African set up, "the sick person is in danger of failing, giving up or doubting and eventually feels abandoned" (Echema 2006:127). Although Echema is commenting from a Nigerian context, his perspective is similar to Chavhunduka, especially as he argues that African people are not sure as to which religion to take and which one to abandon, thus they allow two faiths to co-exist, resorting to each as the occasion demand (Echema 2006:36; see also Healey and Sybertz 1996:294). This explains why some Methodist members moved out of the church to form their own African independent churches. On one hand, this syncretic behaviour among Africans in general is confirmed by Amanze (1998) who argued that the use of traditional medicine is not condoned in the mainline churches and members visit traditional healers. Mucherera (2001) and Kurewa (2000) agree that mainline church members in Africa have many challenges in dealing with healing ministry as Africans. The

two scholars accuse mainline church members as oscillating between mainline churches and AIR. According Healey and Sybertz, the African dualistic catch-22 was sensationalized by a Zairean poet: “O unhappy Christian, Mass in the morning witchdoctor [sic] in the evening, amulet in the pocket sepulchre around the neck [sic]” (1996:294).

Kurewa (2000:10) validates that there are traditional rituals performed by African Christians in secret. A Christian would go to a *n’anga* (traditional healer), herbalist or medicine man/woman either with a child or for himself or herself (2000:10). What is sad about this situation as expressed by Kurewa is when those Christians come back to the church, they will never share these experiences with other church members or with the pastor; such an experience remains a family secret. Mucherera thinks this situation is a result of the sense of double consciousness, a split personality of being half that is felt by many Zimbabwean Methodists (2001:9). These Africans are influenced by dualities of two cultures, two morals, two value systems and two worldviews – African and western (Mucherera 2001:9). Kurewa (2000) notes that this vacillating behaviour is made possible by the situations when the church members walk through the valley of the shadow of death alone without any member of the church or pastor being aware because they both know that this is not allowed by the policy of the church. The two United Methodist scholars bemoan the fact that the church has preached against such AIR(s), without looking at the plight of their members and their community in which they live (Kurewa 2000; Mucherera 2001). This understanding of the healing needs by Kurewa and Mucherera had a contribution to understanding the conflict between the missionary healing and the African healing methods.

African worldview with regards to witchcraft, evil spirits and healing is so robust that most members of the mainline churches remain ambivalent with their faith. Mwaura (2000:77) has a feeling that the big question to be answered by African scholars is: how can the Church in Africa inculturate itself in the African worldview and thereby make Christianity comfortable in Africa and the African Christianity likewise comfortable in the Church? From the question raised by Mwaura, one can envisage the Methodist Church in Zimbabwe in MEM societies grappling with the missio-cultural understanding of healing ministry in their context. Kurewa seems to be right as he argues that blame for the rift between mission and culture, which African scholars are struggling to mend through the inculturation process, should not be the blame of the missionaries (2001).

Kurewa raises a critical question: what is preventing the African church today from using its own culture to communicate the same gospel even more effectively? (2000:12). Arguing from the question above, it is somehow clear that the contest between the missionaries and the identified Methodists who formed their own churches was premised along such questions. Kurewa further questions the logic of Africans on their interpretation of traditional means of healing as evil. He queries: “why should Christianity sacrifice a person’s life just because the only source of healing is at the hospital or a clinic that could be miles away?” (Kurewa 2000:12). Kurewa seems to propose that healing should be inculcated if the MCZ’s mission in MEM societies is to be effective.

Mndende contends that no one is converted to ATR; a person is born into this spirituality and every individual belongs to a larger community, and this sense of belonging is demonstrated by a person’s participation in the religious life, cultural events, and some rituals in some given communities (Mndende 2015:16). Methodist members at MEM societies are all Africans by birth, culture and religion. Their syncretic behaviours make sense, especially that they do it secretly, because it is not allowed by the church. It is easier then to assume that these members have a quest for a hybrid faith. This is probably the reason why it is a challenge for Africans in general and “some” MCZ members in MEM societies in particular to partially declare their spirituality to either ATR or Christianity because the two masters demands the similar attention. For Masaka and Makahamadze, in ATR God dwells among the people, unlike the missionary God who is remote and unconnected to the welfare of his people (2013:133). Mungany and Buitendag differ with other scholars who pinpoint mainline churches as the major culprits of syncretism⁴⁸. They argue that “deeply committed Christians faithfully attend church services on Sunday, pray to God but in the times of need, they turn to the exorcist for deliverance from spirit possession, the traditional healers for healing, to a diviner for guidance” (2013:6). Berends provides justification for what he views as the major reasons why many mission churches fail to wean their members away from traditional medicine (1993:276). The list includes treatment, prevention, and protection against agents of evil, decontamination, ensuing success, retribution, exorcism and eradication of witchcraft (:276).

⁴⁸ “Syncretism as a tendency to combine Christian and African traditional beliefs which in their view, do not belong together” (Muzorewa 2000:114).

Berends further adds diagnosis as another key factor of syncretism among the mainline churches although syncretism remains common among Christians (:276). From as far back as the period the missionaries arrived in Zimbabwe, the quest for hybridity by Africans has always been evident. It became more pronounced during the 1950 and 60s, as will be discussed in this chapter. Methodist members found themselves torn between the two worlds in the search for healing. However, ATR will be lucrative because of the number of advantages cited, apart from being a diagnostic, curative, preventative and causative religion (Berends 1993:278). Milingo does not have sober words for the missionaries who ministered in Zimbabwe. He states that, “many missionaries could not help Zimbabweans on their healing needs given that they failed to appreciate their spirituality especially *mashave* (evil spirits) as disease worth healing since they call it by their name as a hysteria and psychosomatic diseases. They then criticized anyone engaged in fighting this imbecile as anyone chasing wind” (1986:73). Given the facts provided above, the contestation of healing ministry between the missionaries and the Black Methodists was more pronounced in the persons of Mai Chaza, Mwazha and Manhango since it had become common for the local Methodists to do a limping dance between ATR and Christianity.

4.3 Missionary Approaches to Healthcare System

The missionaries arrived in Africa and found that Africans had their own means of healing. According to the World Council of Churches (WCC), “medical missions came to existence during the nineteenth century, leading to the setting up of church-related care systems in many parts of the world where missionaries were active. Healthcare was seen by some as an essential part of the mission of the sending church or missionary organization” (2005:27). “Although these mission hospitals provided compassionate care of high quality at low cost, the western medical models of healthcare was often superimposed on indigenous local cultures with their own therapeutic and healing traditions” (2005:27). Mission and culture were never fused together in Africa. According to Mawire, one of the perennial fallacies by the missionaries was the notion of the so-called “primitive” people in reference to Africans (2015:47). One missionary, Rev Grey, called the locals savages, “meaning Africans were the most difficult people to understand” (Madhiba 2000:26). Missionaries did not recognise the authenticity of shrines, temples or idols when they came to Zimbabwe and concluded that the locals had no religion, culture or intelligence (Idowu 1965:25). This biased

understanding led the missionaries to impose their western modes of healing, which they thought were more superior to that of the Africans, through the building of mission clinics.

Some of the cultural beliefs that the missionaries misunderstood was the idea that illnesses could be caused by ancestors or magic convocation of an enemy. Such an African belief system was difficult to comprehend by the European missionaries, who were unwilling to relearn from other people whom they dismissed as culturally inferior to them (Makoti 2012: 14). Shoko argues that:

Whenever the Shona are struck with misfortunes or bereavement, they attribute this to the angry ancestors because the ancestors are responsible for the welfare of the clan or extended family lineage. Ancestors are also the guarantors of an orderly society and human behaviour and any violation of that society livelihood makes them angry thereby punishing the culprits with illness or misfortunes which range from barrenness, miscarriage, illness, death, unemployment or poverty (2007:8).

Sawyer concludes that Christianity was not planted in the African soil to experience the African atmosphere (1997:9). This point was emphasised by Parratt (1997:3) who stated that the Christianity brought by the missionaries never appealed to the hearts of the Africans. This situation produced an unhealthy relationship between the missionaries and Africans. Missionaries also regarded the context of Africa as a “Dark Continent” that needed to be shown the light of Jesus Christ (1997:3). Mbiti lamented that “missionaries had a tendency to condemn most aspects of traditional religion and society as the work of the devil. They regarded Africa as a cursed land almost entirely in the power of the devil” (2000:91). Mbiti “further argued that the missionaries thought that Africa; the ‘Dark Continent’ would be won to Christianity and civilization through them” (2000:91). This ill-informed perspective says more about the arrogance and ignorance of the Euro-centric missionaries rather than African civilization that has been in existence for many millennia.

According to Mbiti, religion is often compared to the air one breathes. Religion is a constitutive mark of the African identity (1970:2-3). Mucherera contends that “religion is the heart of Africa and African people in generally do not know how to exist without religion” (2001:25). The evangelisation methodology that was employed was determined by which one brought the best results. Therefore it was evangelisation through education or medical mission that became the most popular method because indoctrination through

schools and medical institutions was the most effective way (Mbiti 1970:91). In spite of the divergence in the methods of evangelization, all missionaries were one in their negative attitude towards the traditional culture and religion (1970:91).

The Protestant missionaries' lack of interest in the healing ministry contributed to the resulting dissatisfaction of members and many converts felt frustrated by the missionary churches (Makoti 2012:136). Along with the abstraction of having to submit to the missionary authority, that dissatisfaction led to the formation of African indigenous churches. Africans led these and incorporated spiritual healing as part of their Christian practices (2012:136). One notes that the indigenous churches like Guta Ra Jehovah (GRJ), African Apostolic Church, the Voice of God Apostolic Church and Harvest Apostolic Ministry (HAM) emerged from the MCZ because of the theological controversies on healing ministry. GRJ, African Apostolic Church and the Voice of God will be analysed in this chapter since they were led by lay people protesting against the missionaries in the twentieth century, and HAM, which is led by a former Methodist minister, will be discussed in the next chapter given that it is a twenty-first century development.

4.4 The Question of African Healing: The Nineteenth-Century Dilemma

The nineteenth century AICs secessions either in MCZ or other mainline churches throughout the African continent shared a common perspective that western Christian approaches to the African worldview, as introduced by European missionaries, was not suited for African people. As Kaunda (2017) argues, the rise of AICs suggested that it was not Christian faith that most African people rejected, rather the approach that western missionaries had taken in their introduction of Christianity. Three characters, namely Mai Chaza, Paul Mwazha and Loveless Manhango, have been identified to demonstrate the missio-cultural confrontation between the missionary healing and the African way of healing. The three independent church leaders are an example of the behaviour of Africans when they are confronted with contesting faiths. They either embrace the two and come up with a hybrid faith or commit themselves partially to ecclesia.

4.4.1 Mai Chaza and the Formation of the Guta Ra Jehovah (GRJ)

The first woman to dispute missionary medicine in the 1950s was Theresa Nyamushanga commonly known as Mai Chaza (Ranger 1995:61). There is lack of consensus on her professional development, with scholars giving different accounts especially on how she became a faith-healer, and her contrasting accounts about her ‘death’⁴⁹ and resuscitation. Two of these accounts were by Martin (1971) and Scarnecchia (1997). According to Martin, (the first female to study about GRJ in 1953-4), “Mai Chaza became ill and was assumed to be mentally deranged therefore her husband sent her back to her parents in accordance with the Shona tribal custom” (Martin 1971:110). It is claimed by this religious group that Mai Chaza got worse and finally ‘died’. However, after some hours, she ‘rose’ from the dead because God told her that her ‘death’ was premature (:111). Martin further claimed that “God instructed Mai Chaza to stop her wicked ways and engage into faith-healing⁵⁰ of barren women, the sick, the blind, the cripple and of those possessed by *mashave* (alien spirits)” (Martin 1971:111; see also Scarnecchia 1997:17).

Scarnecchia (1997:91) further stated that “Mai Chaza, was a member of the Methodist Church, previously married to Chiduza and were living in Concession, north of Salisbury. When her husband’s sister died in 1948, she was accused of bewitching her” (1997:90). Mai Chaza was then “driven from her home and went looking for somewhere to live and she ended up in Highfield Township in Salisbury (now Harare) where a Methodist family took care of her” (1997:90). Scarnecchia claimed that, “one day there was food wrangle in this family which resulted in Mai Chaza’s ‘death’. The husband in the house sent for the *n’anga* (traditional healer) to administer to her”. The sending of a person to seek the *n’anga* explains how Mai Chaza, though a Methodist member, believed in traditional healers. Upon arrival

⁴⁹Mai Chaza’s claim of becoming seriously ill, “dying” and “resurrecting” appears to be one of the features of founders of AICs. In the 1950s, the female founder of one of the big AICs in Zambia, Lumpa Church, Lenshina and Johane Masowe, also share the same claims. According to Hinfelaar, Mulenga “died” and people prepared for her burial but after few days, she slowly gained consciousness and to everybody’s surprise claimed she had met Jesus who sent her back with the new message and a new commitment to establish a church (1991:99). Johane Masowe’s claims occurred in the 1950s as well. Engelke states that Shonhiwa Masedza became seriously ill, he could not talk, walk or eat for a week and appeared dead. In the morning, he revived and he changed his name Johane Masowe (John of the Wilderness of Africa) claiming that he has seen Jesus and was given a divine appointment to focus of those who are ill (Mukonyora 1998, 2007; Shoko 2007; Engelke 2007; Ranger 2008).

⁵⁰ According to the British Methodist Church former Health Advisor, Howard Booth (1988:25), there is nothing called faith-healing because it is not about our faith nor the faith of the one prayed for that makes a person to be well, but it is praying in faith that heals (Booth 1988:74)

of the *n'anga*, Mai Chaza was already 'dead', to everyone's amazement she came back to life, claiming that she had been attacked by the spirit of her dead sister-in-law" (:90). She also claimed that "she had gone to heaven where she was charged by God to return back since her death was premature" (*African Weekly* 3 November 1954). It is however not within the scope of this research to verify the facts surrounding the two accounts, but what remains significant for this missio-cultural study is the fact that Mai Chaza was a Methodist Ruwadzano/ Manyano (RM)⁵¹ member who through 'death' and resuscitation believed that she was commissioned by God to heal and was given special healing gifts (Hallencreutz 1998:299; Martin, 1971; Scarnecchia 1997; Dube 2008; Chara 2016) whilst she was a Methodist member.

"After her alleged resurrection, Mai Chaza was went to Chiwako Mountain which she renamed Sinai to receive heavenly powers to perform her divinely appointed duties of healing" (Martin 1997:111). While in another mountain called Mt Hunde, she also received hymns, now incorporated in GRJ, in addition to the old Methodist Hymnbook which the church also uses (Hallencreutz 1998:301). On return from the mountain, Mai Chaza was able to heal the sick and had a strong conviction that she was sent by God to preach and to heal (Martin 1971:111). During that time, she was an active member of Gunde Methodist Church in Kwenda Circuit. Scarnecchia claimed that after conversion, "Mai Chaza became a *n'anga* in Highfield and she could charge people to foretell the source of their illnesses (1971:92). Some fellow Methodist members in Highfield tried to reprimand her, arguing that Methodists do not believe in traditional healing, but she insisted on continuing with her healing practices. Instead, Mai Chaza requested permission from the church leadership to preach her new faith in the Methodist Church in which case church leaders flatly refused (:92). A closer look at Mai Chaza's actions demonstrates her zeal to inculturate healing ministry in the Methodist Church but could not be given space.

4.4.2 Mai Chaza's Healing Ministry and its Impact to the Methodist Church

⁵¹ According to Banana, Ruwadzano is a Shona name and its Ndebele equivalent is Manyano (1996:95). The movement was an extremely hierarchical and elite-conscious organisation of African women (see also Mujinga 2017). The fact that Mai Chaza, as a Ruwadzano member, was able to challenge the men and women of the church's hierarchy, meant that class issues were present from the beginning. Moss describes "Mai Chaza's church as a 'Ruwadzano breakaway'. She adds that although she had similarities with other African Initiated Church leaders, it was her connection to the Ruwadzano that helped her gain legitimacy" (Moss 1992:165-167; see also Scarnecchia 1997:89)

The non-acceptance of her healing work within Methodist by the church leadership eventually contributed to Mai Chaza's movement, taking the institutional identity of being an indigenous African Church. In 1954, she decided to work on a large scale as an independent Methodist faith-healer (Hallencreutz 1998:299). This development can best be interpreted in terms of conflict of power between her own claim for direct divine inspiration and the pressure of institutional structure and order in the Methodist denomination (:299). Mai Chaza's healing mission was a serious provocation to theological, patriarchal and governance heritage of the Methodist Church (:299).

According to Dube, Mai Chaza was a threat because of her anti-establishment patriarchal biased language (2008:1). For Dube, Mai Chaza was attempting to recover the lost identity of women in the male dominated Zimbabwean Christianity. Mai Chaza later moved to Seke area and she was allowed by the Headman Chihota⁵² to perform the healing in Kandava Village. She remained a Methodist when she established herself in Seke Reserve. She was dressed in RM uniform⁵³ when she practiced her healing ministry (National Archives of Zimbabwe (NAZ)⁵⁴ 1954:239/23; Hallencreutz 1998:302). Kandava was under the vast Nenguwo Circuit⁵⁵ and there was a Methodist society there. It could be argued that Mai Chaza used her Methodist identity to legitimise her own unique theological understanding as being 'orthodox' with the same tradition as John Wesley. In spite of opposition from the Methodist leadership and many other people, Mai Chaza's ministry became popular. According to Martin, people who visited Mai Chaza for faith-healing included those from South Africa, Botswana, Mozambique, Zambia and Malawi. The people stayed in a house

⁵²The relationship of Mai Chaza, Headman Chihota and Nenguwo Circuit is worth pursuing. According to Hallencreutz (1998:302), Headman Chihota, who accepted Mai Chaza, was related to Rev Simon Chihota who was the Superintendent of Nenguwo Circuit. Rev Chihota was one of the first African ministers who joined the Methodist Itinerant (fulltime ministry) in 1931-1969 (Banana 1991:223). Headman Chihota, representing the structural powers, had no problem in Mai Chaza practicing her healing ministry in his area (Hallencreutz 1998:303). His brother Simon whose pastorate included Kandava Reserve had reservations on the healing ministry of Mai Chaza. The two brothers were grandsons of Chief Chiremba who received the missionaries in Epworth (Thorpe 1951:160). Chiremba, a 'wandering witchdoctor' was persuaded to settle down at the kraal of chief Chirimba in Epworth (Gundani 2007).

⁵³ Ruwadzano/Manyano in the MCZ is commonly identified with its uniform which has a red blouse, black skirt and white collar and hat (MCZ 2012). According to Chirisa, the uniform has a black skirt which purports the past sins, the red blouse symbolizing the blood of Jesus washing away the sins, and the white collar and hat which stands for new life which is fulfilled in Jesus Christ through the Holy Spirit. The five buttons with one on the belt stands for the five wounds of Jesus on the cross (1991:45).

⁵⁴ A consent letter was written to the National Archives of Zimbabwe to seek permission to research on Mai Chaza and permission was granted. The archives are situated in Gunhill, Harare and they can be conducted at archives@archives.gov.zw (see appendix 8).

⁵⁵ Nenguwo Circuit was one of the first evangelical destination and where Waddilove Institute was built.

that was built for this healing ministry and it eventually gave birth to the African church called Guta Ra Jehovah (City of God) because its followers called themselves soldiers of the City of Jehovah (Martin 1971:111).

As the GRJ movement grew, Mai Chaza earned many titles that describe her as a healer. She was called “Healer” or saviour, one of Jesus’ Christological titles, “*Muponesi*, ‘Redeemer’, *Mutumwa*, ‘Messenger’ or ‘Angel,’ *Gwayana*, ‘The Lamb’ (Martin 1971:112; Dube 2008:12-14). “Some of her followers described her as *Matenga*, loosely translated as ‘Heavens’ arguing that her healing powers were from God (Banana 1996:96). Mai Chaza was also referred to as *Musiki* ‘Creator’ and *Mwari* ‘God’ (Dube 2008:12-14). All the titles were an attempt to describe the healing powers of a Methodist Ruwadzano woman – Mai Chaza. Banana prefers to call her prophetess, healer and non-conformist extraordinary (Banana 1996:96). One notes with interest that some ministers in the MCZ have also been using titles such as prophet, apostles and man of God, because of their involvement in the healing ministry (see Minutes of Conference 2011 and 2014).

4.4.3 Mai Chaza’s Healing Ministry at Guta Ra Jehovah

Guta Ra Jehovah became a healing centre where Mai Chaza, a Methodist Ruwadzano/Manyano member, gathered many people possessed by all kinds of spirits (Martin 1971:111). In the opinion of Martin, Mai Chaza had no intentions of starting her own church but hoped to carry out her preaching and healing activities within the framework of the Methodist Church in order to connect her healing work with John Wesley. However, her major challenge was her rejection by the church authorities (:112). As such, the establishment of GRJ had a negative effect on the local Methodist Church which led to the decrease in church attendance at Kandava (Hallencreutz 1998:302). It is important to note that the challenges of Mai Chaza were not unique in Southern Rhodesia, but also in Northern Rhodesia⁵⁶ where in the same period of the 1950s, “a woman by the named of Leshina Mulenga also formed her Lumpa Church in opposition to the missionary church and the colonial administration” (Hinfelaar 1991:99). The decline in membership happened in spite

⁵⁶ “The modern day Zimbabwe was called Southern Rhodesia while Zambia was named Northern Rhodesia during the colonial era. The names Rhodesia came from Cecil John Rhodes” (see also The British Empire Northern Rhodesia 1955).

of the fact that Kandava was central to Methodism dominated by a benign if not conservative influence of the Epworth Mission (Wood 1978:178). Rev Simon Chihota, a leading minister, did not quickly intervene although he discouraged his members from participating in what he understood as certain “heathen praxis” (Hallencreutz 1998:302). Rev Chihota claims that Mai Chaza advised her followers to pay a certain fine to the spirit and this money is thrown into the veldt. Rev Chihota had other reservations about Mai Chaza’s healing ministry because she had not transferred her church membership to Nenguwo Circuit nor did the Methodist Church authorities in Harare recognize her mission. Mai Chaza acted on what she identified as her own divine inspiration and she remained content with the conformation of her calling that she had received from Paul Mwazha⁵⁷ who laid hands, anointed and blessed her in order to begin her healing ministry (Banana 1996:97).

Mai Chaza’s healing ministry did not only affect the Chihota families but also Epworth Circuit which is one of the areas under study. Rev Heath (one of the missionaries who had been stationed in Epworth Circuit) had seen incipient interest in Mai Chaza’s healing community among the church members (Hallencreutz 1998:303). Rev Heath inquired from Rev Chihota who had not visited Kandava. Heath’s inquiry prompted Rev Chihota to appoint a team of Men’s Christian Union⁵⁸ to investigate what Mai Chaza was doing and the effects of her activities on the local community. Of interest to note is that the team went with a letter from an African Methodist Minister to an African Methodist faith-healer upon the instruction by the missionary. The letter raised questions about Mai Chaza’s formal relationship with the Methodist Church and by what authority she pursued her healing mission (Hallencreutz 1998:303). The questioning of the healing authority of Mai Chaza by Rev Simon Chihota implies that the minister was committed only to the missionary teachings that did not believe in his own people’s African spirituality.

Apart from the missionaries’ conflict on the understanding of healing ministry of Mai Chaza, there was also a negative influence from the African ministers. What is more interesting is that the relationship between the two brothers, Rev Chihota and Headman Chihota, was so bad that it resulted in an attack and defence of Mai Chaza. The hostility

⁵⁷ Paul Mwazha wrote his autobiography in the two volumes of English and Shona. The English title is called *The Divine Commission of Paul Mwazha of Africa Part I*, while the Shona literal translation of the book is *Kutumwa KwaPaul Mwazha we Africa Chikamu Chechipiri* 1998. His healing theology will be discussed in this chapter.

⁵⁸ Men’s Christian Union refers to the Men’s fellowship who subscribe to the organization.

between the two leaders also resulted in Evangelist Ben Shamuyarira, who headed the delegation sent by Rev Chihota, being denied access into the village. Instead of letting them convey Rev Chihota's questions to Mai Chaza, Headman Chihota claimed to be the right person to give authoritative answers (NAZ:239/23). Headman Chihota criticised his brother for having initiated the enquiry. When the team was finally allowed to enter Kandava Village, they conducted a service that was boycotted by the Headman and his people (Hallencreutz 1998:303). The interchange of words in communication between the Chihotas had serious consequences and Rev Chihota decided to close Kandava Methodist Church in his circuit. He also advised Mai Chaza to leave the circuit and go to a place where she was known (Hallencreutz 1998:303). Headman Chihota agitatedly preserved Mai Chaza and allowed her to carry on with her healing ministry within the community. The contest between the two Chihota brothers is a typical example of the conflict between mission and culture in the Methodist Church and the attempt to understand healing ministry.

Mai Chaza was gifted in faith healing especially attending to barren⁵⁹ women (Hallencreutz 1998:303). When GRJ was established in 1954, four persons from the vicinity of Kandava village were healed, ten of them were crippled, two women were barren and they conceived (1998:303). Hallencreutz quotes the son of Mai Chaza as saying, "disease often had special causes which expressed itself in the obsession with 'evil spirits'" (1998:303). Mai Chaza combined exorcism and confession. In an endeavour to spread the influence of her healing ministry, in July 1954, Mai Chaza attended to her first European client, Mrs Hawkins, who had been paralysed in her right side, and whose husband brought her to the GRJ (1998:303). After a few days of prayer and treatment, Mrs Hawkins could stretch out her hand. After three weeks, she was able to stand. When it was heard that Mrs Hawkins was able to run and carry heavy things, healing activities increased at GRJ (1998:303).

Hallencreutz confirms that, "one Chief Nyandoro was healed and another woman who was barren was also healed. When she had sex with her husband after leaving the GRJ she

⁵⁹ Childlessness is a serious concern among the Africans. According to Makoti (2012:39), barrenness is of one of the reasons why people drift to indigenous churches including that of Mai Chaza or traditional healers. For Marie-Louise Martin, a barren wife in African society is like a dead end (Martin 1971:112). Martin adds that, in view of this, it is dangerous to be barren, therefore the people in the Karangaland lay its main emphasis on curing barren women (Martin 1971:121). This is equally so with the traditional Karanga religion, which encourages barren women to go to the cult centre of Mwari to ask him for children. Shoko (2007:60) writes that they "believe that barrenness is caused by a number of reasons that includes failing to pay *mombe youmai* 'mother's cow' by the son in-law and is attributed among misfortunes in the Shona spirituality" (see also Gelfand, Mavi and Drummond 1985:36).

became pregnant, two mad men were also healed” (1998:303 see also African Weekly 9 March 1954). All the healing activities took place during the first four months of Mai Chaza’s new extended healing mission and as a Ruwadzano member (1998:303). Although it is difficult to refute the healing powers of Mai Chaza, Chara (2016) however exaggerated her gifts by stating that Mai Chaza was capable of healing more than 8 000 people in a space of two hours. Chara’s claims of Mai Chaza entitlements that attempted to deify her has been criticized by Daneel who argues that the “GRJ movement should not be classified among the African indigenous Churches because Mai Chaza has deliberately replaced the Bible with a revelation book of its own and produced a highly heretical reinterpretation of the Holy Trinity in which Mai Chaza is elevated to become one of the members of the Trinity” (Daneel 1987:253). However, considering that Chara obtained the information from the members of GRJ, it is not surprising given that one member claimed that, “although Mai Chaza had a human body, she was actually a god... and is seen in the company of the angels” (Chara 2016). According to Hallencreutz, Mai Chaza left Kandava in 1956 and healing ministry was attested to by more than thirty-five articles and testimonies in the African Weekly Newspaper (1998:304).

4.4.4 Methodist Church’s Response to the Healing Ministry of Mai Chaza

The increasing public interests of Mai Chaza made her keen to have formal recognition by the Methodist Church (Hallencreutz 1998:304). She decided to return to Salisbury and present her case to the Methodist leadership. Mai Chaza knew the Superintendent of Salisbury African Circuit⁶⁰ Rev Fredrick Rea (1998:304). She returned to him with the hope that he might be the proper authority to talk to. Regrettably, Rev Rea was not ready to assist her because Mai Chaza operated in another Circuit (Kwenda). Instead, Rea sent Mai Chaza

⁶⁰ Salisbury African Circuit refers to the modern day Mbare Circuit which is one of the areas under study. According to Makombe (2013: xvii), the Harare Township was a municipal location designated as such in 1907 and after some years of being referred to simply as the Salisbury Native Location. In April 1982, the capital of the newly independent Zimbabwe – Salisbury – was renamed Harare and the Township renamed Mbare. The influence of Mai Chaza to Epworth Circuit was discussed earlier. However, here one notes that the healing ministry of Mai Chaza also had influence on Mbare Circuit in the 1950s.

to the Chairman⁶¹ of the District and General Superintendent – Rev Jesse Lawrence⁶² – with an introductory letter. The letter written by Rea demonstrated interest to find ways to keep Mai Chaza within the Methodist framework (Hallencreutz 1998:305). An analysis of this point shows that although Rev Simon Chihota was not interested in the healing ministry of Mai Chaza, some Methodist missionaries were concerned but needed to do this in a diplomatic and official administrative way. Rea seems to embrace a positive or more open outlook regarding the healing ministry of Mai Chaza. He had realized the temptation to write Mai Chaza off simply as a traditional healer and recommended that her special gifts should be nurtured and used within the Church (1998:305). He encouraged Mai Chaza to undergo a formal test as a Methodist Local Preacher⁶³ while at the same time continue with her healing ministry (1998:305). In addition, Rev Rea advised Rev Lawrence to make his assessment and to encourage the local clergy to try to improve relationships with Mai Chaza (1998:306). Lawrence followed Rea's advice and tried to find out more of Mai Chaza's background. He met her and discussed possible forms of her work within the regular activities of the local church (1998:306). Lawrence discussed his findings with Rev Simon Chihota and encouraged him to develop contacts with Mai Chaza without committing himself to everything that was going on at GRJ. Rev Chihota took his Chairman's advice seriously and acted accordingly (:306).

In February 1955, Rev Chihota agreed with his Assistant Rev Oswald Ramushu and the local Preachers in Nenguwo Circuit on a plan for a service in Mai Chaza's healing

⁶¹ In 1977, when the Methodist Church received autonomy (independence) from the British Conference, the term changed from Chairmen of the District to President, with Rev Andrew Ndhlela becoming the first Black President of the Methodist Conference (Madhiba 2000:53). The term President has always been a common term for Methodist leaders since 1791 when John Wesley died with the first President being William Thompson in 1791 (Clark 1951:118). The term was carried to all parts of the world where Wesleyan Methodism found roots. In Zimbabwe, the term President changed to Bishop in 1989 (Banana 1991:221). The term Chairman was given to the Ministers who were leading Districts. In 2004, the MCZ further changed the term from Bishop to the Presiding Bishop, referring to the head of the Church, while renaming the District Chairmen District Bishops. The lay leaders who were referred as Vice District Chairmen were renamed District Lay Presidents (MCZ Minutes of Conference 2004:17).

⁶² Rev Jesse Lawrence was the Chairman of the District and General Superintendent from 1954 to 1964 (Banana 1991:220). The term Chairman was used to refer to the Methodist Minister leading the Rhodesian District by the British Conference, the first one being Owen Watkins who brought Methodism to Zimbabwe together with Isaac Shimmin. It might not be surprising that Lawrence gave an ear to Mai Chaza because in describing Lawrence, Madhiba avers that he was a man of strong character and he had confidence in the people. He feared God and worked tirelessly for the localization of Methodism (Madhiba 2000:40).

⁶³ Local Preachers in the Methodist tradition were started by John Wesley himself. In the MCZ, Local Preachers go through a rigorous training so that they will be able take the worship services as appointed by the Superintendent (See also MCZ *Deed of Church Order and Standing Orders* 2007 Section 55: 555-559).

community to join with the Methodists around Kandava area (NAZ 239/5/20/1). The coming together of GRJ and the Methodist Church in 1954 had compromised the Methodist Church in a number of ways. First, GRJ had become a healing church; second, Mai Chaza did not allow any Methodist preacher from the circuit to take services before they took a proper confession because according to her, anyone with a sinful heart would collapse in the pulpit (NAZ 239/23). The Methodist society was therefore used as a base for people waiting for Mai Chaza's healing ministry (Hallencreutz 1998:306). This situation divided the Methodist Church. Local preachers from the circuit did not accept this rule; however, Methodists members at Kandava consented to Mai Chaza's healing decrees (:306). "Faced with this situation, Rev Simon Chihota and Fredrick Rea approached a man called I.H. Samuriwo, one of the people whose barren wife had been released from this disability by Mai Chaza to be the liaison officer between the Methodist Church and Mai Chaza" (Bantu Mirror 12 March 1955). In pursuit of the proposed dialogue, Rea decided to take a Sunday Service in Kandava on 27 February 1955. He was accompanied by Rev Crispen Mazobere⁶⁴ and two local preachers from Nenguwo Circuit sent by Rev Chihota (Hallencreutz 1998:306).

It is not clear, according to Hallencreutz, why Rev Simon Chihota whose circuit had problems with Mai Chaza, decided not to go with this delegation and instead was represented by Local Preachers. There are four reasons that could be suggested to justify his actions. First, tracing the developments of the previous conflicts of the Chihota brothers concerning the healing ministry of Mai Chaza, it can be argued that Rev Chihota wanted to avoid the potential confrontation with Headman Chihota. Second, since Rev Chihota was involved in all of the previous disputes, he therefore requested neutral persons to deal with the issue in order to exonerate himself directly so that he would rely on the reports and act on them for his next step. Third, Rea was positive about the healing ministry of Mai Chaza and sought to influence his colleague Lawrence to robe her into the healing ministry of the Methodist Church. This influence was going to be possible with the report that he was going to write. If Chihota was going to be present, these efforts were going to be fruitless, given that it had become clear from Lawrence and Rea that Chihota was one of the African Ministers who needed to be encouraged to mend his relationships with Mai Chaza. Last, it

⁶⁴ Crispen Caspen Mazobere was one of the leaders of the MCZ for the shortest time of one year in 1981 and later on in 1992-1994. He is also one of the few black Ministers to have a PhD in the early 90s (Banana 1991:224).

can also be claimed that Rea decided to take Mazobere, a young minister still at College, in order for him to interpret the Shona culture within the context of the Methodist traditions which he was also to learn.

The task of the team was to settle the terms for regular cooperation between GRJ and the Methodist Church. However, there were divergences between the two institutions. One of them was that the local Kandava Methodist Church had merged with Mai Chaza's healing community and they were using the Methodist Church building and following Mai Chaza as the new leader (Hallencreutz 1998:306). Rea maintains that a congregation numbered two thousand, and a group of pregnant women in white maternity frocks with the emblem of GRJ formed the choir (:306). The women who were once barren would be swaying and clapping hands. Along the line, the prophetess Mai Chaza was touching, praying and squeezing their bellies. Headman Chihota claimed that sixty-eight of the women in the choir had once been barren and were expecting (Ranger 1995:62). Rea further narrates that;

The singing and general discipline of the service was excellent. After the hymn and before I commenced the liturgy, a man beside me showed signs of being possessed, I walked over and tapped him sharply, immediately another man in the similar plight stopped and there was no further manifestation to any sort morning or afternoon (Ranger 1995:61).

Mazobere narrates the proceedings at the GRJ. He writes that,

After all the faithful had assembled we were waiting in anticipation of Mai Chaza's arrival. We were told by the ushers to go before Mai Chaza. I remarked that according to Methodist practices, the preacher goes in after the rest of the congregation has settled in... Mai Chaza then arrived dressed in full Ruwadzano/Manyano uniform. The ushers reiterated their call for us to precede Mai Chaza while I stood resolute. After respectfully welcoming us, Mai Chaza went before us as per Methodist custom. However, the lay preachers were told they had to be blessed by Mai Chaza before entering the church. I expressed the fact that lay preachers as fully accredited into priesthood were entitled to the same respect as that accorded to ministers. That effectively settled our seeming differences and the service progressed smoothly after which we had an opportunity to appraise Mai Chaza of the problem. She remarked that actions had been presumptuous on the part of some officious members of the congregation and she did not subscribe to high-handedness (Hallencreutz 1998:307; Ranger 1995:61-62).

Both Hallencreutz and Ranger were reluctant to inform us about the actual position that was taken by Rea and his team when they were instructed to go before Mai Chaza, which leaves us with the assumption that the team complied. However, according to Hallencreutz, the mission of Rea and team was a failed enterprise. Hallencreutz arrived at this conclusion

based on the notion that Ruwadzano/Manyano issues were dealt with in Ruwadzano/Manyano Committees, in which case the team was male dominated (1998:307, see also MCZ Ruwadzano/Manyano Administration Policy Book 2013). In a feminist world, this action was tantamount to using male religious power to silence women's ministry. Hallencreutz further advised that, among the members of GRJ, Mai Chaza was regarded as a leader, a position which she did not have in the RM structures where she was just a member with special charismatic gifts of healing (1998:308).

On one hand, Lawrence wanted to maintain the integrity of Nenguwo Circuit, thus Rev O. Ramushu and Nenguwo Circuit Local Preachers continued to go to Kandava for services (Hallencreutz 1998:308). On the other, Mai Chaza had to balance her own loyalty to the Methodist Church against the pressures in her own movement in favour of a more independent institutionalized presence (:308). In 1956, Mai Chaza decided to leave Kandava village and the local GRJ was dissolved and burnt (:308). According to Gandiya, one of the reasons for her dramatic move was that she had become increasingly critical of what she found had become too worldly and institutionalized (1984:21-22). Mai Chaza's success could be because of the shortages of medical facilities and there was a good market for faith-healing (African Daily News 19 Dec 1956). This situation has never changed much because African Indigenous Churches and Mega-Pentecostal churches are still attracting people from the mainline churches, taking advantage of their unanswered healing questions (see also Zimunya and Gwara 2013:90).

Mai Chaza eventually officially started her GRJ as an indigenous Church when she moved to a place called Zimunya, a United Methodist Church⁶⁵ dominated area. However, she continued to wear her RM uniform, exchanging it with a white dress which had become a new uniform⁶⁶ for her female followers (Gandiya 1984:22; Hallencreutz 1998:308; Scarnecchia 1997:99). In spite of wanting to remain with a Methodist identity, Mai Chaza's healing was transferred to Pentecostal movements and African Traditional healers which

⁶⁵ According to Mosley (2007a:1), "in 1950 Southern Rhodesia had a population of about 3¼ million people, of whom 3 million were Africans, and 250,000 Europeans. There were two Methodist Churches in Rhodesia, one linked with the United Methodist Church in the United States of America, working in the Eastern part of the country and the other linked with the Methodist Church in Britain at work in the North, West and South" (2007:1). The main difference between the two churches were their country of origin but they have the same founder – John Wesley (See also Linden and Weller 1984; Mujinga 2017).

⁶⁶ "The uniforms worn by Mai Chaza's followers extended the healing metaphor, as women dress as 'nurses' in uniforms of white, while men wear a khaki uniform with shorts and a military belt" (Chara 2016).

were more receptive to the religio-cultural perspectives and practices (Hallencreutz 1998:310).

Mai Chaza travelled to many parts of Zimbabwe, including Mutare, Bulawayo, Masvingo, and Harare, practicing her healing ministry still as a Methodist member (1998:310). When she returned to Highfield in Harare, she mended her relationships with the Methodist Church (Gandiya 1984:48-51). According to Gandiya, Mai Chaza healed both African and European clients during her stay in Highfield. She however decided to keep a low profile and let her presence be felt by the testimonies of those healed (Hallencreutz 1998:48-51). The excommunication of Mai Chaza only came when one Methodist female member from Kwenda who had been barren but became pregnant had testified that she had been looking for a child for a long time and had intercourse with two Methodist clergy (names supplied by Hallencreutz) without any success (1998:311). Such confession appealed to a wide audience and it became an embarrassment to the Methodist Church. The issue was taken to secular courts where the woman was charged with defamation of character. She was instructed to compensate the two ministers (1998:311). Mai Chaza was advised by the courts that such defamatory confessions should cease in her movement (:311). The matter was taken to Kwenda Circuit Quarterly Meeting⁶⁷ where Mai Chaza had been a member, which decided to finally remove Mai Chaza's name from the Class Book⁶⁸ (Methodist District Synod 1959).

⁶⁷ According to Hallencreutz (1998:29), the Wesleyan Methodist Mission was hierarchical. At the National level there was the District Committee or the Synod under the Missionary Committee of the Wesleyan Methodist Church in Great Britain. Under the District Committee, there was the circuit with the Quarterly Meeting which made the recommendations to the Synod. The circuits comprise of different societies of local congregation (It should be noted that the whole of the current MCZ was once a Synod of the British Conference). The Quarterly Meeting of Kwenda Circuit dealt with the discipline of Mai Chaza and she was excommunicated from the Methodists. The decision was buttressed by the Rhodesia Synod. In the same year, Paul Mwazha, the leader of African Apostolic Church, was disciplined by Kwenda Circuit Quarterly Meeting. In 1954, the Circuit had dealt with the discipline of Loveless Manhango, the leader of Bethsaida Apostolic Church. The three church leaders share a number of common factors. First, they all rose from Kwenda Circuit, second, they had confrontation with the missionaries along the missio-cultural understandings of the healing ministry, third, they all arose during the 1950s, some years after the Kwenda hospital had failed to work, and last, the churches they form are all still functioning in Zimbabwe today and scholars have developed keen interest in researching about these former Methodist members.

⁶⁸ A Class Book is a register for Class Meetings. According to John Wesley, class meetings were centres of discipleship and platforms of spiritual nourishment. Class Meetings had to do with accountability. Wesley called the Class Meetings the "sinew" of Methodism, the "muscle", "genius" or the heart of Methodism. Being removed from the Class Meeting for a Methodist was like being expelled from heaven (Curnock 1916).

4.4.5 The Impact of Mai Chaza's Healing Ministry on the Methodist Church

According to Madhiba (2000:45), the Methodist Church believed that it had been called to care for the sick. However, their mission in Zimbabwe was not well strategized through a clear plan of missional action. Wesley had faith in the healing power of God and it was this constitutive mark that shaped Methodism (Makoti 2012). In early Methodism, healing was carried out in a variety of ways, including deliverance, miraculous healing, and exorcism. However, these missional tenets were not intentionally and consistently applied and maintained in the identity, vocation and witness of the Methodist Church. Instead, the church built medical missions to oppose faith healing. Faith healing was viewed as a factor which could lure converts into superstition and magic (Makoti 2012:20). Faith healing was thought of by the missionaries as a revitalization of traditional healing which would persuade local members to go back to paganism (Madhiba 2000:45). The coming of Mai Chaza into the healing ministry fraternity caught the Methodist Church by surprise. A case in point is the issue of one of the Methodist ministers, Rev Thompson Samkange⁶⁹, who found his faith struggling between the Methodist theology of healing and Mai Chaza's theology.

Although Mai Chaza eventually formed her church, she only ceased to be a Methodist member for less than a year, starting 1959 when she was excommunicated, to 1960 when she died. Her ministry however spanned from 1954 to 1960 and had a great impact on both

⁶⁹ Rev Thompson Samkange once worked in Kwenda Circuit and was gifted in spiritual healing. While working at Kwenda Circuit, it was the same time when Mwazha, Mai Chaza and Manhango also came out of the Methodist Church and formed their own churches. According to Ranger (1995:61), Samkange sent in a very good Christian girl who had been having strange sleeps to Dr Steyn at the Dutch Reformed Church Hospital in Morgenster requesting Steyn to take her so that her family would not initiate her into the *shave* (evil spirit) cult. When Samkange's daughter Norah became ill, she was also referred to this hospital and it was discovered that she was barren (1995:61). In 1952, she developed a phantom pregnancy. Her father confessed to have been baffled by her symptoms because the western medicine could do nothing to help her (Ranger 1995:61). In desperation for the child and escape from the censure of the husband's relatives, she joined the GRJ movement (1995:61). Samkange and his wife Grace were distressed to see their daughter committing herself to what they regarded as a pervasion of Ruwadzano zeal and the Young Women's Christian Union which she had been a leader at Pakame Circuit (1995:62). Ranger (1995:79) and Makoti (2012:11) stated that Samkange was regarded as one of the Methodist Church prayer giants, however, ministry was unable to help his own daughter and family in need. According to Ranger (1995), many people flocked to Samkange prayers for the sick and the Presbyterian Clinic Manager also confirmed that Samkange healed the manager's wife by strong prayers to God after failure to be helped by western medicine and by the Presbyterian Church (Ranger 1995:80). Norah, Samkange's daughter did not bear any child and when she eventually died, Mai Chaza's GRJ were asked to conduct a service for the daughter of the Methodist clergy (Makoti 2012:62). Such actions left the Methodist Church clergy torn between cultural healing and western methods of healing. The situation was exacerbated by the fact the Samkange was one of the respected ministers, and yet his daughter left Methodist church for a church which was condemned by most African ministers.

the Methodist Church and in other African contexts. Her followers expected her to rise from the dead not only spiritually, but also physically (Martin 1971:112). It was against this background that her grave was left open for days (1971:112). The history of Mai Chaza's healing miracles is very important because there are a number of lessons that the contemporary MCZ can draw from her ministry.

4.5 Paul Mwazha and African Apostolic Church (AAC)

4.5.1 Early Life of Paul Mwazha⁷⁰

Mwazha was born a Catholic and was educated at Kwenda, a Methodist school, and worked as a Salvation Army Church Officer then reverted to the Methodist Church before receiving what he termed as a 'divine calling' that propelled him into founding his own African Apostolic Church (AAC) (Banana 1996:182). According to Ndlovu, "AAC is one of the fastest growing AICs in Zimbabwe and is popular in both urban and rural areas. Its influence has changed the religious landscape in Zimbabwe" (2013:49). Given the medical challenges in Zimbabwe, many people cannot afford to visit medical institutions, as such, AICs have appeared to be a solace to their healing needs. The miracle of Mwazha's life started when he was still young. He claimed that "soon after his birth, he fell seriously ill with the dreaded influenza and his deeply devout Roman Catholic mother Sarimana took him to the parish priest for baptism so that when he died his soul would not be condemned to purgatory" (Mwazha 1998). Mwazha claimed that a miracle occurred as he was being baptised and that he was brought back to life at the moment of baptism (Mwazha 1998).

At eleven, Mwazha started Roman Catholic Catechism classes but changed to the Methodist church a year later since he attended a Methodist school. Banana reports that at the age of twelve, Mwazha came to recognise the miraculous power that he had through prayer in 1934; while he was praying, he went into trance during which he saw 'the image of God' (Banana 1996:182). Mwazha was later trained as a teacher at a Salvation Army Institute – Howard – in Mazowe north of Harare in 1941 (Mwazha 1998). In 1948, Mwazha was sent

⁷⁰ See footnote 35.

to Chideme as a Headmaster and Evangelist⁷¹ of the Methodist Church and schools (Gondongwe 2011:227).

4.5.2 The Spiritual Life of Paul Mwazha

Mwazha spent most of his time praying and singing during his youth (Mawire 2015:52). He would have these private moments interrupted by the voice from above giving him distinct messages and more often he would witness ‘physical visions of Jesus’ and revelation on what the future held (Mawire 2015:52; Mwazha 1998:1). In 1950, Paul Mwazha was given permission by his Methodist missionary Superintendent of Kwenda Circuit, the Rev H.H. Morley Wright to pray for the sick (Mawire 2015:59). This was an honorary role given in respect to lay persons (:59) to do the duties of what would normally be reserved for the clergy. Wright also gave Mwazha this authority because he was convinced that Mwazha had a special gift of healing (:59). In one of the Quarterly Meetings in Kwenda Circuit, Rev Wright reported that Mwazha has the gift of healing, and that he conducted faith-healing at Sadza⁷² Methodist Church where many people recovered astoundingly in the name of Jesus (Methodist Church in Rhodesia, 1954).

According to Mawire (2015:59), the remarks by Wright did not go well with the lay leaders in the circuit, who argued that the minister was supporting Mwazha on wrong things. However, Mwazha did not stop praying for the sick, especially Methodist members (2015: 59). Mawire records one of the special healings where Mwazha healed a woman who was bedridden for two weeks and was unconscious. Relatives had stayed at her home for two days anticipating her “death” then the family agreed to call Mwazha who went there with William Dune and Dutoit Kepekepe⁷³ (2015:59). When Mwazha arrived, he was told that people had two requests to God –either the woman should get up, walk, eat and drink, or die. Mwazha and the people gathered around the sick person singing a Methodist Church hymn, *Dombondipa meso ndione* (MCZ Shona Hymn 255, Ndebele Hymn 259), literally meaning ‘give me eyes to see’ (Mawire 2015:59). After the singing, Mwazha was filled

⁷¹ The concept of teacher and evangelist was introduced by the missionaries when they came to Zimbabwe to introduce Methodism. They brought ten teacher-evangelists from South Africa who were going to help them propagate the Gospel among the Africans because they believed it was only an African who could convert a fellow African (see Makoti 2012).

⁷² Sadza Methodist Church was one of the societies in Kwenda Circuit but has since been divided from Kwenda Circuit to be a standalone circuit with 13 societies (MCZ Handbook 2016:103).

⁷³ Dutoit Kepekepe later moved out of the MCZ to form his African Initiated Church, the Voice of God in Africa, based in Kwenda.

with the “Holy Spirit” and he prayed and the woman began to talk (2015:59). Kepekepe claimed that it was not a healing miracle but a resurrection because the woman had died (Mawire 2015:60).

Mawire’s report cannot be verified because he was reluctant to make a follow up in order to conclude such a definitive point made about resuscitation, resurrection or exorcism. In his reluctance, Mawire comments that it is not in the interest of this work to establish whether the woman was actually healed or she was in a state of comma (2015:59). Mawire’s unverified claim must therefore be treated with suspicion, especially that he concluded that “what is important for the author is that, a miracle took place and many people believed that Mwazha was really a man called by God” (2015:59). Mawire also remarks that the western medicine was “too limited in extent and seemed unable to reach the cause of such sickness” (:59). Although the conclusions by Mawire seem to be faith assertions rather than scholarly claims, what is important is that, in the absent of other sources, his claim cannot be accepted as factual.

The healing miracles of Mwazha, whilst still a Methodist Evangelist, did not occur without causing problems in the wider Methodist Church. In 1959, when Mwazha was stationed at Kwenda mission, he resigned from the Methodist Church as Head Teacher and Evangelist (Ndlovu 2013:49). Mwazha claimed that he had the power to heal diseases such as asthma, diabetes, rheumatism, anaemia, anorexia, migraine, period pains and post-natal depression (Gondongwe 2011:227). These claims created contention and division with the missionary leaders and they became a seedbed for missio-cultural confrontation. Rev H.H. Morley Wright who had supported Mwazha accused him of demonic ways of healing within the Methodist Church (Mwazha 1998:1). The hostilities between the missionary and his evangelist continued unabated, and when the situation became unbearable, the evangelist left the Methodist Church (Gondongwe 2011:227). An analysis of the arguments raised by Gondongwe seems to suggest that the relationship of Wright and Mwazha was very good at the beginning but eventually became much soured. According to Gondongwe, although Mwazha had links with Roman Catholic Church, Salvation Army and Methodist Church, he decided to form his own AAC (:227). For Gondongwe, the establishment of this church might have been a quest to establish his own identity (:227).

4.5.3 Mwazha's Healing Methods

According to Mawire (2015:53), in 1953, the World Council of Methodism at Oxford called for Methodists everywhere to a time of renewed consecration and witness. In response to this call, Rev Herbert Carter, then General Superintendent and District Chairman of Rhodesia (Zimbabwe), sent a pastoral letter to the Methodist Community for people to attend “cottage prayers every Wednesday or on the evening of any other day in the week. During the prayer sessions, they were not supposed to be alarmed when they noticed great things as the Holy Spirit of God empowering some people for a mission” (Mawire 2015:53).

The contents of the letter had some aspects of alerting the Methodist Community to receive the supernatural occurrences freely without fear (2015:54). “Mwazha took the letter from Rev Carter as a greenlight to the mission that had already started. He claimed that while he was singing Methodist hymnal, God granted him the gift of transforming the negative into positive” (Mwazha 1998). Mwazha states that, “I could through prayer ask the Lord in his power to make it possible for the barren to have children or those who had boys only and wanted to change could have girls” (Mwazha 1998:2). Mwazha cites an example of one couple who had no child. He claim that “I felt sorry for them because death had left a heavy laden on them and had deepened a sense of guilt, a feeling of negligence, unworthiness and suspicious in their parents. They were prayed for and gave birth to eight children later (1998:3).

For Mwazha, as long as Jesus Christ healed the sick, raised the dead and cast out demons, he was called to do that at no cost (1998:20). Mwazha also claimed to deal with witchcraft, bad luck, barrenness, sorrow, blindness, sorcery, severe depression, and loss of hope – problems that were dealt with by Jesus and thus he also has such powers (:20). According to Mwazha, God gave humanity the gifts of healing as the supremacy over evil, and the ability to receive messages and guidance of prayer, visions and dreams in the name of Jesus Christ (1998:20). The interdenominational night vigils led by Paul Mwazha increased, during which healing and deliverance took place. According to Mwazha, the gift of healing was not a prerogative of one person (Hallencreutz 1998:314). It is because of this reason that Mwazha left the Methodist Church and also parted ways with Mai Chaza to form his own African Apostolic Church. His church has grown to include followers from across the Southern African Development Community (SADC) and the United Kingdom (Chitumba 2015). Ndlovu claimed that AAC is aggressive in deploying a unique theology and self-

understanding (2013:49). Although Mwazha had left the Methodist Church for over 58 years, he still claimed to be a Methodist because for him the Methodism that was started by Wesley was corrupted in Zimbabwe (Mawire 2015:53). Drawing from these narratives, healing ministry remained central in the Methodist Church but was suppressed for a long time.

4.6 Loveless Manhango and the Formation of Bethsaida Apostolic Church⁷⁴

4.6.1 The Early Life and Call of Loveless Manhango as a Faith-Healer

The third Methodist member who also established his own church was Loveless Matarirano Manhango “in September 1952” (Madzinga 1976:2). Loveless Manhango, Paul Mwazha and Mai Chaza came from the same area of Kwenda Circuit (Mawire 2016). Manhango went to Chisangano Methodist School in 1947 at the age of 18. In 1948, Manhango became an “On Trial member” of the Methodist Church (Mawire 2015:2). He was baptised in Save River⁷⁵ by Rev Wright⁷⁶. Manhango left the church in 1950 because Rev Wright had told him about the requirements of the church, that every full member must have a wedding, and he did not like this idea. In retaliation, Manhango started to drink beer, smoke and did not care about his family. Eventually, he went to Chegutu where he started to do brick moulding contracts (2015:10). On September 20, 1952 around midnight, God spoke to him (Madzinga 1976:2). According to the testimonies of Manhango, he heard the voice of God calling him from a worldly evil life (BACW Website 2016). These revelations triggered the beginnings of Manhango’s healing ministry.

After this theophany, Manhango claimed that he saw fourteen visions which strengthened him and gave him insight on what was to come (BACW 2016). “These visions made his heart fill up with joy that God had truly chosen him to do his work and he felt the burning desire to start preaching and heal” (BACW 2016). The following morning, he terminated the brick moulding contract with Mr Eric of Chegutu (BACW 2016). Manhango returned back to Kwenda. He narrated his encounter with God to his family members (BACW 2016). In spite of his call, Manhango continued with his Methodist Church membership at

⁷⁴ The establishment of Bethsaida Apostolic Church has been written about by Madzinga the General Secretary of the Church in 1976 in Shona book entitled “*Mavambo eBethsaida* Apostolic Church.

⁷⁵ Save is the biggest river that stretches across Kwenda.

⁷⁶ Rev Wright is the same missionary who had problems with Mai Chaza and Paul Mwazha until they both moved out of the Methodist Church.

Chisangano Society in Kwenda Circuit (Madzinga 1976:13). Meanwhile, he also started to pray most of his time in Mount Chiwiriri (which is the current headquarters of the Bethsaida Apostolic Church) (BACW 2016). The whole calling story is not immediately clear from the information given by Madzinga his biographer as to whether Manhango had remained a Methodist Church member while he was in Chegutu where he started his ministry. The lack of evidence compels the researcher to assume that Manhango encountered the theophany but was no longer a Methodist church member, as argued earlier, therefore, chances are that considering the influx of traditional healers during his time, he might have been using African traditional methods of healing. Many sick people went to Manhango seeking help and were healed, as narrated by Madzinga (1976:13).

The wedding issue was repeated to Manhango, to which he complied, and he eventually became a full member⁷⁷ of the Methodist Church (BACW 2016). Manhango further claim that people started to come to him for prayers (1976:13) and he would pray, heal and exorcise the evil spirits (1976:12). Manhango prayed for the sick at their homes and at his home until they were healed. Twenty-five children from a Catholic School got manifested by an evil spirit and their parents were called to school. The parents brought the children to Manhango for healing and all went well (1976:13). Although Manhango healed many people, he remained a Methodist member (:13). Madzinga further reported that one man was seriously ill and was taken to the clinic and later to Harare Hospital, the second largest medical centre in Zimbabwe, where his disease was pronounced untreatable. The family agreed to take the man to Manhango who prayed for him and he was cured (:15). Manhango argued that the evil spirit cannot be determined by doctors (:15). Another healing report of Manhango was of a woman from Harare who drank coke and water for seven years. When the woman was brought to Manhango, she was prayed for and was healed (:15). All these healing reports however lack clarity concerning the method of prayer offered by Manhango since he was once a traditional healer.

⁷⁷ Full Members in the Methodist Church refers to those members who have been baptized and confirmed and they partake the Holy Communion (MCZ *Deed of Church Order and Standing Orders*. 2007:5).

4.6.2 The Methodist Church's Response to the Healing Ministry of Manhango

The healing ministry of Manhango faced a great deal of resistant from the Methodist Church in Kwenda. Manhango claimed that the Methodist leadership believed that healing ministry was not the work of the lay people but the clergy who had gone to the theological college (BACW 2016). Sadly, there are no records from the Methodist Church to ascertain this claim. Manhango reported that, in performing the healing ministry, he was going against the rules of the Methodist Church (BACW 2016). The first step taken by the Methodist Church was to invite Manhango for a disciplinary hearing at Chisangano Methodist Church in 1956. The meeting was chaired by the Evangelist Mugwendere who instructed Manhango to stop the healing ministry and praying for the people. Manhango did not concede to this instruction (BACW 2016). When the Methodist Church leadership realized that Manhango rejected their command, they banned him from praying at the Chisangano School and instructed him to do so at his home.

The next step taken by the Methodist Church was the appointment of Rev Brandon Graaff as Superintendent Minister of Kwenda Circuit at Chisangano Church (Banana 1991:225). Rev Graaff invited Manhango to the church service and during the service, Graaff saw the miracles that he performed (BACW 2016). Graaff admitted⁷⁸ that Manhango was doing a good job and that God was using him to do his work as a pastor (BACW 2016). Two more meetings were called in 1956 at Chisangano Methodist Church to discuss the future of the healing ministry of Manhango and he was requested to go for theological training but refused stating that God had sanctioned him with his own message (BACW 2016). Although Manhango claimed that his refusal to go to theological training was based on his call as a healer, it could be argued that since his education was below the standard expected to engage in theological education (see *Deed of Church Order and Standing Orders 2001*), he was being set up by the ecclesial system to fail and so lose respect among the people.

⁷⁸ It is important to remember that when Mai Chaza started her healing ministry, Rev Fred Rea confirmed that she was called by God. The same happened with Rev Morley H.H Wright who also commended the healing ministry of Paul Mwazha. This time again, we are learning that Rev Graaff appreciated the healing ministry of Manhango. One notes with interest from these discussions that the missionaries were eager to let the African means of healing ministry be introduced among the Africans, however, what seemed a big challenge was with the fellow African members.

The Chisangano Leaders Meeting insisted that Manhango should not heal people in the Methodist Church (BACW 2016). Rev Graaff made another trip to Chisangano Methodist Church. It was on a Sunday and the church was full with sick people⁷⁹ who had come for the healing service (Madzinga 1976:16). After the service, Rev Graaff asked people who had been healed to narrate the methods used by Manhango (Madzinga 1976:17). During the testimony time, the healed people confessed that they were healed by Manhango, in which case the missionary would correct them to say they had been healed by Jesus (1976:17). Rev Graaff further instructed Manhango not to heal in the Methodist Church or school, for fear of controversies. Manhango was also denied the authority of 'laying on hands' because the MCZ consider this to be the work of trained ministers only (1976:17).

The crisis did not subside and Rev Graaff decided to return to Chisangano again. He told the society that, "Manhango, was doing ministerial duties and yet he was not a minister and that he had no theological training. All who are supporting Manhango are going against the Methodist Church theology of healing" (1976:18). At that point, Graaff divided people along the lines of those who support the Methodists and those on Manhango's side. Madzinga commented that very few went to the side of Manhango, including those whom he had healed (1976:18). Madzinga interpreted this action as a silent protest because people were only afraid of being officially excommunicated from the Methodist Church (1976:18). The action of dividing people between the Methodist Church and Manhango created a major challenge for the followers. One woman had the audacity to stand up and claim that, "I give all my offerings, but I am poor. I was ill, but I was healed by Manhango" (1976:18). The woman further questioned the Methodist leadership, saying, "is being healed by Manhango a crime and yet I give my offering?" This was the last day Manhango attended the Methodist Church (BACW 2016).

The next step was the official pronouncement of Manhango having left the Methodist Church. Madzinga claims that Manhango started to preach, heal, exorcize and prophesy (BACW 2016). Some Methodist members would be seen visiting his new African Initiated Church in 1954, the same year Mai Chaza also began her healing ministry and formed GRJ. Manhango claimed that he had a vision of women wearing red blouses and belts, blue skirts, white hats and colours, praying and healing the sick. These colours became the uniform for

⁷⁹ This is the same situation that was observed by Rev Fred Rea when he went to Kandava the same year to see how Mai Chaza was practising her healing ministry (Hallencreutz 1998).

the women's organization (BACW 2016). The colours of BAC are almost the same as those of MCZ. The meaning and significance of the uniform was discussed earlier (See Footnote 52). However, Manhango argued that in his church, the blue colours represents the Holy Spirit. (BACW 2016). It is worth mentioning that there is not much difference in the relationship that Manhango and Mai Chaza had with the Methodist Church.

Before concluding this chapter, there are four critical observations to be noted. The contestations between the missionaries and the locals were evident. However, the support of Mai Chaza, Mwazha and Manhango by the missionaries during the 1950s and 60s suggests that if healing ministry was given space, MCZ would have emerged with a developed inculturative healing ministry. First, Africans believe in traditional ways of healing. The way Mai Chaza, Mwazha and Manhango practiced the healing ministry is what some Methodists in the selected societies are craving for. Second, Methodists always wanted to inculturate healing ministry but the internal pressure from both the missionaries and the fellow Euro-centric Black clergy leaders became a hindrance. Third, people who move out of MCZ, whether voluntarily or involuntarily, still feel obliged to remain connected with the mother church. Last, the quest for healing ministry in the MCZ is not new.

4.7 Conclusion

In concluding this chapter, the missio-cultural confrontations between the missionaries and the local healers reveal how the missionary healthcare system failed to attract the locals. The chapter deliberated on the African traditional ways of healing which Mai Chaza, Mwazha and Manhango were familiar with. It was also expounded that Mai Chaza and Manhango were actually involved in the African traditional way of healing. When their spirituality confronted with the missionary spirituality, there was tension. It is important to appreciate that although Mai Chaza, Mwazha and Manhango were oscillating between African forms of healing and western faith, the missionaries were supportive of the healers. Mai Chaza was backed by Rev Fred Rea and Jesse Lawrence, Mwazha was supported by Rev H.H. Wright, while Manhango received support from Rev Graaff. The conflict between the Methodist ecclesial system of mission and evangelisation revealed that its ultimate loyalty was to its Euro-centric origins which were thought to be orthodox and superior rather than to engage in mission and evangelisation as accompaniment with the real life situations of the local people. The missionaries therefore promoted those local African leaders that

mimicked European religio-cultural worldviews and values, and opposed those that advocated for Afro-centric worldviews and values. Those local leaders that demonstrated their commitment to exercise their ministry were denied equal place within the Methodist Church and therefore had to move out and form their own AICs.

The depth of this religio-cultural crisis and the psycho-social consequences on local African leaders is revealed in the misplaced passion and rejection by some African Methodist clergy leaders of their own local leaders. This suggests the depth of self-hate and rejection of their own heritage and identity because of uncritical allegiance to the missionary worldview. The inculturative process of healing ministry in the Methodist Church draws inspiration from the ministry of Mai Chaza, Mwazha and Manhango. The next chapter will discuss the theological approaches to healing ministry that were taken by MCZ.

CHAPTER FIVE

HEALING MINISTRY IN THE SELF-GOVERNED MCZ

5.1 Introduction

The previous chapter has discussed the missio-cultural conflicts between the missionaries and the locals which led to the formation of three African Initiated Churches (AICs), namely, Guta Ra Jehovah, African Apostolic Church and Bethsaida Apostolic Church. The chapter also highlighted that during the infancy period of the ministry of healing within AICs, some Methodist missionaries were more sympathetic to the locals than some local clergy in MCZ. However, it was also the missionaries who were at the forefront of excommunicating the African faith-healers. Thus, the chapter exposed the inherent contradiction that existed within the Methodist missional understanding, vocation and witness as it engages with the religio-cultural context of the peoples of Zimbabwe. This chapter explores the healing ministry that evolved within the self-governed phase of MCZ since 1977, the year Methodism became independent in Zimbabwe. The independence of Methodism in Zimbabwe will be discussed using two approaches; the first one being the independent Methodist in a colonized Zimbabwe from 1977 to 1980, then the independent Methodist in an independent Zimbabwe. This chapter will demonstrate that the European dominance in Zimbabwe was strong.

The road to autonomy was not easy both politically and theologically. In 1977 the British Methodist Conference approved a statement on healing. This document is significant because it coincided with the approval of MCZ autonomy during that same year. The chapter also examines the healing approaches undertaken by the independent MCZ that include the use of Francis MacNutt's book on *Healing* (1974). The evangelism programmes that define MCZ's theological approach to healing ministry will be examined along with identifying the shortcomings of the theological approaches that gave birth to the continuous splits that led to the formation of Harvest Apostolic Ministry under the guidance of Claudius Matsikiti⁸⁰ and Revival Fires Apostolic Church founded by Eden Chombo. Finally, a study

⁸⁰ Claudius Matsikiti was a Methodist Minister and resigned in 2004. He was at one time Connexional Evangelist, and phase two of the Evangelistic programme happened during his time. He moved out of the Methodist Church to form his African Initiated Church called Harvest Apostolic Ministry. One of the major reasons being that he was now going to extremes with the healing ministry and as such his resignation was a way of engaging in healing ministry fulltime.

will be made of healing ministry in AICs in relation to MCZ's teachings and the MCZ's approaches to healing ministry in the face of HIV and AIDS.

5.2 Independence vs Dependence: The Methodist Church in Zimbabwe's Dilemma

The experiences of ecclesial disunity caused by missio-cultural misunderstandings contributed to the breakaway formation of AICs in the 1960s, and this resulted in local pressure from the people on the leaders of the Methodist Church to change the approach to healing ministry. This is the same period when prominent African theologians like John Mbiti and Bolaji Idowu introduced indigenized theology as the way forward for African churches to indigenize their ministry, mission, evangelism, liturgy and pastoral work (Martey 1993). The pioneering work of Mai Chaza, Mwazha and Manhango was a wakeup call for the MCZ to think of inculturating its theology on healing ministry and also to facilitate the radical missional formation of local leadership that takes seriously the religio-cultural heritage of local people by seeking to enculturate the gospel within their local culture. Madhiba called this process "localization", to describe how Methodism changed its leadership from the missionaries to the locals. The localization process was completed in 1977 when Methodism was given independence from the British Conference.

Although Madhiba prefers the term localization, given the challenges of the term as critiqued in African theology, his use of the term is restricted to his role as a Church historian who was more concerned about the localization process as merely a pastoral tactic, and an exchange through interaction between the local culture and the missionary's communication of the gospel (Newbigin 1980). Localization however, is not without its own African theological critics that accuse its advocates of focusing too much on locals taking over the governance of inherited Euro-centric institutions rather than focusing on refashioning how Christianity is inculturated within African context (Gilgalo 2012). Localization takes a point of departure that Christianity is not local but a foreign faith that should be made local and therefore does not fully transcend the indigenisation process. The localization process of theology must therefore experience three stages, namely, dialogue, engagement and conversation. This process does not, according to Madhiba, constitute one in which the Africans impose themselves, and the missionaries giving in, but that there must be a transition of increase in local control of the mission and decrease in foreign until the local takes full control (Madhiba 2000). Such a kind of approach by Madhiba did not make the gospel and culture equal partners in the process of evangelisation. Therefore the concept

and process of inculturation remains the best term to be used to facilitate the gospel and culture dialogue in African Christianity (Idowu 1973; Mulago 1969; Bediako 1992, 1995; Antonio 2006; Shorter 2006).

Localization as an approach was mostly used by the European missionaries because it gave them veto powers and control over the process of localisation, to ensure that the process would be drawn out for as long as it is possible, and the African would never ultimately be in control of the mission. African Theologians, especially those of Protestant heritage, preferred the term contextualization. In early period, some preferred to use adaptation and indigenization (Idowu 1973; Mulago 1969; Bediako 1992, 1995). According to Dickson, indigenization means that the gospel should be interwoven with cultural vestments which the missionaries consider to be at peace with the Gospel message. Nevertheless, intercultural questions both the cultural container and the very gospel concerning how it is inserted in a new culture and the ways in which it affirms the human dignity of the people.

Localization as a process of recruiting the local people of different cultures as clergy (Newbigin 1980:110) is even worse in the discourse of missio-cultural examination of healing ministry within MEM. For the Europeans, there was never as good a time for the localizing of Methodism in Zimbabwe than 1977. The first justification being their 1950s-60s missio-cultural confrontations with the locals. Second, the political unrest in Zimbabwe also made the missionaries to lose trust among the locals. The best move for them was to give the church independence in a colonial country as a bribe to the locals, in order to monitor the missio-cultural confrontations in the future. It is not easy to conclude that when the country was occupied by the British, the same British gave autonomy to the church in Zimbabwe, given that church and state traded together. What seems obvious is that the missionaries wanted to change leadership but remain in power through local personnel whom they knew would not challenge them, through maintaining resources, and theologically by maintaining their doctrines (See also *Deed of Church Order and Standing Orders* 2007).

Madhiba divided the localization process into two main strands, namely, deliberate and spontaneous localization (2000:40-58). Deliberate localization refers to the attempt by

Rhodesian District to undertake measures of Africanizing⁸¹ Methodism continually (2000:49). The localization process also took into account the efforts made by the Methodist Missionary Society (MMS) to reinforce the acceleration of the localization process. Moreover, spontaneous localization denotes the process of making Methodist local without pre-arranged plans or discussions (2000:50). For Madhiba, spontaneous localization would also happen without notice – the church leadership would find itself locked up in a localization process it cannot reverse, for example the use of *hosho* (rattles) and wearing uniforms (2000:51). Magesa confirms this point, stating that prayers, songs, signs and symbols in the church should reflect the cultural richness of the locality (2004:31).

By inculturation, the MCZ becomes a church that identifies with the historical experiences of the locals. Given this meaning of localization, Africans demanded that among the missionary initiated things to be localized was the healing ministry. It can be argued that some leaders within the Methodist Church regarded an African understanding of healing to be important because diseases are believed to be ‘caused phenomenon’ and for them to be healed, a diviner must be consulted (see also Shoko 2003, 2007a, 2007b and 2011). This localization process was not possible with the missionaries being part of the Rhodesian Methodist District. In view of this, the MMS’s approach to the localization process was to slowly withdraw the missionaries. Although Madhiba argues that the removal of the expatriates was a dangerous move because the local ministers were few and there were no finances to support even the few local ministers⁸² (2000:56), the question is then, when should localisation begin? What seems true is that there is never a right time for localisation as long as the imperial missionary model of ministry was in place. This was in essence all about how power was managed by the missionaries.

In 1960, the Secretary of Africa, Rev T.A. Beetham, visited Rhodesia District Synod. He was convinced that Rhodesia Synod had come of age and should brew its own form of

⁸¹ Africanization in African Theology means letting the local church to be led by Africans (Mpagi 2002:117). It is putting Africans where Europeans used to be; as such, the term becomes more political than theological.

⁸² The point of supporting the locals financially was well presented by John Gatu, the former General Secretary of Presbyterian Church of East Africa, in the 1963 All African Conference of Churches and was repeated in the same meeting in Zambia in 1971. Gatu raised what he called moratorium (Reese 2012:1). In coming up with this term, Gatu succinctly states that moratorium not only calls that mission and evangelism should cease, but a call for the temporal delay in sending missionaries from western churches to the developing countries (:1). Although Madhiba is raising the issue of localization of African leadership, he falls in the shoes of Gatu as he states that moratorium is self-reliance where churches in Africa should call a halt to the flow of missionaries’ person and funds from other countries at least for a period. This would be a strategy to allow the churches in Africa to make sure that they have their own identity and integrity (Cassidy n.d: 265).

Christianity. In his address to the Synod, Beetham states that, “there is no rationale behind separating evangelism programmes between whites and blacks because the mission is for the locals and not missionaries” (Minutes of Rhodesia Methodist Synod 1960:54). Drawing from Beetham’s statement, one notes that he was responding to the AICs that were born from the split of evangelism programmes that did not offer much to the African spirituality, where they would “drink from their own well” (Gutierrez 2003).

In his annotations, Beetham also called for the expatriate missionaries to cultivate positive attitudes towards the values of the local people (Minutes of Rhodesia Methodist Synod 1960:54). This statement can be argued to mean that Beetham was calling for the integration of mission and culture, which Hewitt (2012) terms as missio-cultural process. The points raised by Beetham were inclusive of the African understanding of healing that were grounded in African culture. This point was raised by de Gruchy and Chirongoma who argue that inculturation is found on moulding the Bible and symbols (culture) of Christianity into a profoundly African expression of the church (2010). This argument is consistent with Beetham’s perspective in having an imagination of a Methodist Church that is home grown and not an extension of British Methodism in Southern Rhodesia. In view of this point, one would take the debate of Madhiba to move from the localization of the church to its indigeneity where a church is emerging and nurtured with African soil.

According to Beetham, for the Gospel to be heard and Christ to be encountered, the preacher should value the hearer and preach for the audiences (Minutes of Rhodesia Methodist Synod 1960:55). Beetham encouraged evangelism programmes to be localized, including healing ministry. Beetham rejected the notion that Britain should aim at making every African country into a typical European nation because that was impossible. Rather the aim should be to create reciprocal cultures in which the best of Europe converses with the best that is local (see also Maluleke 1998:15-16). African values were to be brought together (Minutes of Rhodesia Methodist Synod 1960:54). The mutual dialogue between European missionaries-introduced Christianity and African culture is what is termed here as inculturation. Upon Beetham’s return to Rhodesia in 1961, he further announced that the Synod needed to apply for autonomy since other Synods had started to function with some form of autonomy (Minutes of Rhodesia Methodist Synod 1961:60). Jesse Lawrence, reflecting on the experiences of the 1950s and the split of Methodists, saw this move as a good opportunity for the church in Rhodesia to become inculturated. Lawrence proposed

the division of the Synod into three areas to function as the Districts of the Rhodesian Conference (Minutes of Rhodesia Methodist Synod 1961:62). Lawrence's decision did not go down well with his fellow missionaries because some were not yet prepared to hand power to the locals. This point was stressed by Elwell who argued that Christianity from the west was not prepared to learn how to trust in indigenous people to be able to follow God's leading. The missionaries failed to trust that with the help of the Holy Spirit, the locals were capable of working to maintain the purity of the church in a local context (2001:1161).

This conflict with some missionaries is not surprising in the inculturation process because according to Waliggo and Karamaga, for inculturation to be achieved, the message of Jesus Christ must be communicated with clarity to African people in their local context. Theology must also address meaningfully the circumstances of African life and thought (1991; see also Pobee 1979; Nyamiti 1994; Bediako 1995; Mugambi 1995). Inculturation challenges were not unique to the Zimbabwean context but were also in the Catholic Church in Zambia with Milingo's inculturated approach to healing ministry (Kaunda 2017; see also Ter Haar 1992). These scholars conclude that such a move will give us as real *theologia Africana*, a true African Christian Theology. In view of this, autonomy was a non-starter to some missionaries, meaning that Africans were supposed to embrace the missionary healing ministry approach, which for them, was also a non-event.

In 1962, there was much tension in the Rhodesian District and Lawrence was clear on the approach of the church. He states that,

It is the right of every person to be allowed to develop his or her potential abilities and that every person must be at liberty to express his or her religious opinion, to engage in worship in his or her own way and to express his or her opinions on social and political questions free from fear of physical violence, mental or social coercion (Minutes of Rhodesia Methodist Synod 1962).

These approaches were steps towards genuine inculturation of the church. However, the road has not been smooth. Limited localization only became a reality in 1964, when the first local person, Rev Andrew Ndhlela, was appointed to lead the church as the Chairman and the General Superintendent (Madhiba 2000:48). According to Madhiba, when Ndhlela took over the helm of the Methodist Church as the first black leader, the church had 39 local ministers and 38 missionaries. One notes that the church was slowly becoming indigenous (Madhiba 2000:48), however, the 39 black ministers were European in their mind. However, the challenge is that to become local does not necessarily mean that the church becomes

indigenous or inculturated. It can simple be “Black skin with a white mask” (Kumalo 2009). This was a serious challenge, even to the understanding of the healing ministry in the Methodist Church, given that those African ministers were only Africans in origin but European in their theology.

The areas where Britain colonized, they also planted churches. However, for the British Conference to give these churches autonomy, many things had to be considered. For churches to be effective, prosperous British communities were required to transfer authority to Africans or Asians. However, the word transfer is relative since the missionaries remained in total control of the church. The desirability of training an indigenous minister was not in question, but the debate for years was how soon autonomy should be granted and the practicality of taking that route (Madhiba 2000:58). The British Conference wanted first to come out with a criterion by which to judge the person’s suitability and the sort of training and probation that were required. Such an action was a form of governance to ensure that even after “independence”, the British church would maintain veto powers over the local church. Second, they also wanted to establish whether the country needed supervision or to allow the church to minister in remote appointments. Third, they wanted to establish the number of native ministers who could be effectively supervised and what should be entrusted to them and expected of them from the missionaries. Fourth, they sought to assess the suitability of the Circuit Superintendent Minister and the one who was to be the District Chairman since many countries in Africa and Asia were districts of the British Conference (:58). With the criteria mentioned, the leader was supposed to prove beyond reasonable doubt his ability to lead the local church. It meant that the individual was supposed to inculturate the gospel, and healing ministry was a key issue considering the 1950s experiences of break away in the Methodist Church giving birth to of Mai Chaza, Mwazha and Manhango forming their own AICs. However, this point is not solid enough to justify the localization process. The approach could mean that the leader to be chosen would be the one most suited to maintain continuity with the British Methodists rather than to foster inculturation of the gospel.

5.3 The Autonomous Methodist Church and its Response to Healing Ministry

The year 1977 is significant in the history of the Methodist Church in Britain and the Methodist Church in Zimbabwe. First, the British Methodist Conference made a resolution on health and healing named: *A Methodist Statement on the Church and the Ministry of*

Healing. This statement was not only effective for the British church but also the Zimbabwean church. Second, the British Conference also granted Rhodesian District autonomous Conference (Mosley 2007b:1). The Rhodesia Methodist Church became autonomous before the country became self-governing in 1980. According to Zwana (2011), autonomy to the Rhodesian Methodist Church meant that the Church could plant and implement its mission work in its country. This mission would be defined by the cultural milieu of the people. In addition, being autonomous meant that the Methodist Church would be self-ruling, self-governing, self-supporting and self-directed by its own conference (Madhiba 2000:52). Given the self-reliance of the church as Madhiba would want us to believe, healing ministry in the Methodist Church remained a foreign mission. This is evidenced by the *Deed of Church Order and Standing Orders* that was signed by the Rev Andrew Ndhlela on behalf of the new Conference. The Deed in part states that:

Whereas the Deed of Foundation dated 16 October 1977 has constituted the Methodist Church in Zimbabwe as an autonomous community of Christian believers... Whereas the doctrinal standards of the MCZ as started in the Deed of Foundation are as follows... MCZ cherishes its place in the Holy Catholic Church.... The evangelical doctrine to which the Preachers of the MCZ both Ministers and Laypersons are contained in Wesley's Notes on the New Testament and the first volume of his sermon..... A foundation of the Conference has been held in accordance with the Deed of Foundation and has settled and adopted this Deed of Church Order to be the Constitution of the Methodist Church in Zimbabwe (MCZ 2007:2).

After the declaration, the *Deed of Church Order and Standing Orders* goes on to give the definitions of membership, baptism, the Lord's Supper, responsibility of members and definitions of different terms to be used by the autonomous Church (MCZ 2007:4). Regrettably, healing ministry was never mentioned. Even after 40 years of autonomous mission, up to 2017, MCZ still grapples with the definition of healing ministry and yet it is an African church, with African leaders and ministers, using African forms of worship but not daring to approach healing ministry in an African perspective. Although autonomy also means that the Church does not answer to another church or organization for any of its decision, a closer look at the *Deed of Church Order and Standing Orders* of the MCZ, which is the church's policy book, shows that the document has presented itself as a caretaker manual for the British Church, given that MCZ does not own it theologically. In view of this situation, one can conclude that to certain extent, the autonomy was limited because it appeared that the British Church maintained some veto powers concerning Methodist theology in Zimbabwe.

The British Methodist still act as the surrogate father of the MCZ given that the Euro-centric theology continues to define the local conference. This point can be supported by the name Methodist Church “**in**” Zimbabwe. This situation is in contrast to the sister conference, the Methodist Church of Southern Africa (Kumalo 2009). In the context of the two Methodists in the global south, the two prepositions ‘in’ and ‘of’ leaves one wondering such a difference. The word “**in**” presupposes that the MCZ belongs somewhere and is operating in Zimbabwe. Although one might assume that the word ‘in’ and not ‘of’ was an emphasis of one Methodist church globally, where ‘of’ speaks to the location from which the church reflects the fullness of life quest, the next question is, why does the South African Methodist Church where Methodism in Zimbabwe traces its roots (Zvobgo 1991), use ‘of’ Southern Africa and not ‘in’ Southern Africa? The two prepositions “in” and “of” are worth pursuing in this section with the aim of finding out to what extent is MCZ a local church with the quest for all Zimbabweans? In trying to respond to this question, two answers can be provided. First, the theology of the British Methodists was a cut and paste to the Zimbabwean Methodist constitution. Second, in choosing of the word “in” Zimbabwe, it seems to emphasise the British dominancy to Methodism in Zimbabwe theologically; and as a result, MCZ is stuck on which move to take in order to inculturate healing ministry. Although other facets of ministry like worship have been inculturated, healing ministry remains debatable in the MCZ theology. The major challenge is agreeing on what is Methodist and what is un-Methodist as far as healing ministry is concerned. As such, missio-cultural conflict has become MCZ’s major challenge over the years.

Makoti could be right to conclude that despite gaining autonomy in 1977, the Methodist Church has not seen beyond its independence in order to address the needs of its members from a biblical, contextual and African worldview (Makoti 2012). The mission of God in healing ministry was seldom allowed by the missionaries and the local Methodists to define itself within the African context. The gospel remained like a flower in a flowerpot that was never transplanted into the African soil to experience the warmth, the heat and air of Africa as it spread its roots in Africa soil. The gospel roots continued to grow without spreading in the flowerpot and this made the flower/gospel to be dwarf. This scenario could be argued to be one of the reasons that led to healing ministry experiencing arrested development in the MCZ; because the gospel remained a potted flower. Gondongwe reinforces this perspective from a church history point of departure by emphasizing that while the church became

autonomous in 1977, this did not bring much change in terms of domination of the indigenous people by the Europeans (Gondongwe 2011). In other words, one can conclude that autonomy for MCZ was implemented selectively. In spite of these challenges, the Methodist Church in Zimbabwe gained the power to select its own leadership, determine the form of worship, decide financial matters and direct other church related affairs without pronounced interference from outside. Nevertheless, its members in Zimbabwe remained schizophrenic as far as healing ministry is concerned.

5.4 The British Methodist Church's Statement on Ministry of Healing

Healing ministry was not only a theological crisis in the Rhodesia Methodist Church, but also for the British Methodist Church. From as early as 1946, the British Methodist Church has been grappling with healing ministry (Holifield 1986:44). In the same year, the British Methodist Society for Medical and Pastoral Practice was formed to promote closer associations between ministers and doctors and to explore the possibilities of spiritual healing (:44). The Methodist Church Britain (therein MCB) acknowledged that healing was not being practiced in all Methodist Churches (MCB n.d). The MCB argued that John Wesley was prompted by the Holy Spirit to preach in the fields and it is the same Spirit that should empower the Methodist Church to take healing ministry forward (MCB n.d). The MCB also confirmed that the church is the safest place to offer healing. It is where healing should begin and not end (MCB n.d). Although the MCB Conference amalgamated medical and pastoral responses to their challenge on the healing ministry, they were not ideal for Africa.

The 1976, MCB Conference resolved three widely held divergent views on demons. First, the conference confirmed that all activities that may be described as “demonic” can be explained in terms other than those supernatural forces (MCB 1976). In this statement, the church confirmed that demons “do not exist” as a form of objective reality. Since the British Conference was giving autonomy, it seems this statement was meant to suppress African forms of healing in Zimbabwe. Second, the Church agreed that the demon may be explained on the basis of psychological and sociological research; and third, the conference confirmed that evil spirits are form of objects reality and can form the cause of conditions that cannot be explained in psychological terms (MCB 1976). An evaluation of the Conference decisions on demonic powers presents a Church that lacks theological interpretation of both the Bible and African worldview. One would understand such a decision influenced by the

secularized theology bequeathed to the British Church from the enlightenment era. The struggle to define demons, whether psychological, sociological or theological, was the bone of contention between the Africans and the missionaries, as already noted in the previous chapter.

In 1977, the MCB Conference published a pamphlet which was a statement of the Church's theology concerning the entire field of healing including some beliefs and general references to faith-healing. According to the pamphlet adopted by MCB Conference,

The church is called to be a community in which the total healing work of the Holy Spirit is taught, sought and experienced. This spirit of healing is present in the worship, sacraments, preaching, prayer, fellowship, pastoral and social ministry and all its members are called to be involved (MCB 1977).

In the introduction, the pamphlet raises a number of questions that implied that sickness is not God ordained. MCB (1977) further states that the huge scale of human suffering is a major obstacle to Christian faith (MCB 1977).

Although the 1977 Methodist statement confirmed that the Christian approach to health and healing is based on convictions about the nature of humanity, the significance of Jesus and the continuing work of the Holy Spirit (MCB 1977), the value of the pamphlet is somewhat limited by the fact that its propositions are expressed in fairly general terms with no biblical references supplied to locate the scriptural context that influenced its theological formulations. The Conference agreed that "the symptoms of man's disease are not all physical. They include guilt, isolation, alienation, lack of love, despair, the breakdown of relationships and particular fear" (MCB 1977). Overall, the statement is psychologically and sociologically rich but has a deep theological vacuum. This is surprising especially coming from the Conference that directly inherited Wesleyan theological tradition. The approach by the British Conference to healing ministry in the same year they granted autonomy to MCZ had a deep influence on the no-committal to the approach that was used by missionaries in defining healing for Africans.

5.5 Healing Ministry Approaches of the Autonomous MCZ

The autonomous MCZ grappled with what its approach should be to the healing ministry in order to be relevant to the people that it serves. The Church took a number of initiatives to

inculturate healing ministry when it took an initial tentative step in 1974 to adopt a book titled *Healing*, by McNutt.

5.5.1 Theological and Academic Approach to Healing Ministry by the Missionaries

The first step by the Methodist missionaries on healing ministry was the adoption of a book titled *Healing* by McNutt (1974). Before analysing the reasons why the Methodist church embraced the literature by MacNutt, it is important to briefly investigate his personality and career. “Francis MacNutt is a former American Roman Catholic Priest linked with the Catholic Charismatic Renewal” (Grady 2004). He learnt about healing from his Pentecostal friends (Kim 1973). “In 1980, he left the Dominican to marry a Southern Baptist Psychologist Judith Carole Sewell” (Grady 2004). This move was not accepted by the Catholic Church because what he had done was anathema, thus he was excommunicated. “The Catholics may have been open to a priest who spoke in tongues and heal the sick, but they certainly would not accept one who broke celibacy vow to marry” (Grady 2004). “MacNutt and his wife went out of the Catholic Church and establish a Christian Healing Ministry (CHM) in Florida upon the invitation of an Episcopal Diocese Church” (Grady 2004). “MacNutt is the president Emeritus of the Christian Healing Ministry. Grady claims that “he heals asthma, allergies, heart disease, high blood pressure and cancer” (2004). Grady goes on to claim that “MacNutt prayed for a woman who then watched her foot grow to its normal size from size 5-7 to 1-2” (2004). This phenomenon is common in Zimbabwe with Walter Magaya the founder of Prophetic Healing Ministries, Emmanuel Makandiwa, the Founder of United Family International Church, among other latest Pentecostal ‘prophets’ (see also Masvotore 2016; Chitando, Gunda and Kügler 2013; Vengeyi 2013; Shoko and Chiwara 2013; Biri and Togarasei 2013; Mapuranga 2013; Mwandayi 2011; Chitando, Manyonganise and Mlambo 2013; Shoko 2015).

The embracing of McNutt’s book on *Healing* by the Methodists was influenced by a number of things. First, the period that Rhodesian Methodist became a conference was marred by political conflict that also entered into the life of the church, with African ministers supporting African Nationalism, while some expatriates were supporting the Rhodesian Front. The armed struggle situation caused some ministers to leave rural circuits for refuge in the more secure towns (Madhiba 2000:58). This situation created some tense relationships in the church. The President (now Presiding Bishop) of the Methodist Church

Rev Caspen Makuzva, writing in 1981, highlighted in his review to Conference on the subject of Evangelism, that,

I see that this year is a year of Evangelism because the country has gone through a terrible time. Fortunately God has worked through this and given us Robert Mugabe as the Prime Minister – a man who preaches reconciliation. This is a miracle. This then gives a platform to evangelize. In addition, war has disrupted people's lives and choked their minds with sin and suffering. There is a need of relief from sorrow and hate, and of reconciliation to each other and to God through the Cross (1981: appendix 1).

The nation needed the healing of memories and MacNutt's book was a relevant resource in the absence of healing resources.

Second, the British Methodist Missionary Society had granted autonomy to the Rhodesian Conference and there were a number of white missionaries who were disgruntled about being led by a Black Methodist President – Rev Andrew Ndhlela. This situation created factionalism in the Church. Be that as it may, MacNutt's book was relevant because it addressed the inner healing of emotional problems (1974). Third, the local ministers were angry with the British Church because it had decided to stop all financial support of the Church activities in Rhodesia. Fourth, some lay people were active in both politics and the Church life, which caused Christians in the same church to be suspicious of each other. And lastly, between 1978 and 1980, the armed struggle identified some Christians as enemies who took sides with the illegitimate minority government against the people's struggle and the church became defenceless (Madhiba 2000:58; Gondongwe 2011). Although the healing needs of the people were a felt need, they were not addressed in the training of ministers through the UTC curriculum (Handbook 2016-2020) nor in how the local leaders of MCZ sought to address the identity, vocation and witness of the new MCZ.

In 1979, the Rhodesian Conference did two significant things. First, they asked the British Conference to appoint an experienced minister for a short period to share experiences and train a selected group of lay people on some technical issues that included reconciliation. The Conference sent Dr. G. Lovell (Minutes of Rhodesia Conference 1979:7). Second, the 1979 Conference also adopted MacNutt's book on *Healing* for the Pastoral Theology course for Methodist ordinands⁸³ being examined by Rev O.P.K. Beecroft. The two measures were

⁸³ Ordination means being set apart for the Word and Sacrament. In the Methodist Church, ordination is also called Reception into Full Connexion (MCZ 2007: 160 item 716). Ministers who are ordained in the Methodist

an attempt to deal with the healing ministry of the church by the missionaries and also to suppress the healing needs of the locals. The book by MacNutt remained a Pastoral Theology set book for MCZ ordinands from 1979–1982 and 2000–2008. Effectively, the book was used for eleven years; the researcher was also examined in MacNutt’s theology in 2004 as an ordinand. It is not immediately clear as to why MCZ used this book for such a long period. Whatever we can suggest will remain exposed to critique.

Although the Methodist Church has used Francis MacNutt’s book for such a long time, one wonders the type of theological emphasis MCZ was trying to instil in its clergy. The ambiguities of using MacNutt are so glaring that the conclusions drawn by Madhiba, that MCZ feels at home in using borrowed literature, become evident (2000). This point is also supported by the stock in the Methodist Connexional Bookshop where most of the literature is from Pentecostal Churches and T.D. Jakes tops the list. There are three weaknesses worth pursuing that can be drawn from using MacNutt as a resource book for ordinands in the MCZ, although there might be many others.

First, MacNutt was a monk who had never been to Africa and had defaulted from Catholic theology. The Roman Catholics had institutionalized healing ministry (Echema 2006) and MacNutt had lost touch with this theology. This point disqualifies MacNutt’s theology as a panacea to the healing needs in the MCZ. Although MacNutt in his book presents his argument most sensitively, pastorally, combining extensive practical experiences, psychological insights and deep in faith in God’s healing power and compassion (Morton Kelsey, back cover of MacNutt 1974), his book never appealed to the African understanding of healing ministry. According to Lartey et al, “members of the community in Africa visit the traditional healing shrines for protection of the evil and curative rituals so that they will not be ill. The traditional healing community then performs a preventative, protective as well as a curative function in the wider community” (1994:32; Kaunda and Phiri 2016; Murove 2009). MacNutt is divorced from the African culture and the use of his book as a set book for ordinands by the MCZ was not helping in the process of inculturation; rather,

Church in Zimbabwe would have gone for three years of theological training at United Theological College or by Theological Education by Extension and three years of probation (MCZ 2007 section 71 item 710-717). During the process, the probationers will be examined in their preaching, work in the circuit or wherever they are attached, book list and oral examination (The Methodist Church Service Book 1992:G1-G15). The ordination is done by laying on of hands by the Presiding Bishop assisted by other Bishops.

it was reinforcing western notions of healing ministry. This point is supported by Chirisa⁸⁴ in his vision for the Church's future towards the centenary celebrations in 1991. Chirisa argues, "the Church has to be aware of the resurgence of interest in African religion and culture ... it seems there is now greater opportunity to understand black Zimbabweans and their culture than before" (1991:175). In which case, MacNutt was an outsider of this theology, which is grounded in Africa.

Second, MacNutt was one of the earliest Catholics involved in the charismatic renewal and in the practice for healing in prayer groups (MacNutt 1974 back cover). Moreover, being a Catholic and charismatic means MacNutt was a rebel since Catholics would not go to these extremes during the time he started his healing ministry. According to Echema, Catholics use the anointing of the sick as one of the sacraments called Extreme Unction during the healing services (Echema 2006). "Catholic clergy perform the healing ministry using various elements like crucifix, holy pictures, candles, holy oil, holy water, medals scapulars, other blessed materials" (Echema 2006:20). However, Heron asserts that prayer and sacraments are channels of the healing love of God. Prayer has always been part of Catholic teaching and practice of healing. For the purposes of this research, Francis MacNutt is discussed not as a Catholic theologian. Although MacNutt's theology of healing became prominent, the first people to inculturate healing ministry in the Catholic Church were Father Augustine Urayai,⁸⁵ a Zimbabwe Roman Catholic priest, in 1960 (Shoko 2006:349), and the Archbishop of Lusaka, Zambia, Emmanuel Milingo, in 1969 (Ter Haar 1992). In view of this point, the MCZ apprehension of MacNutt was a lack of critical appropriation.

⁸⁴ Farai Jonah Chirisa was the longest serving leader in the MCZ after autonomy. He was President from 1986-1991 and the term was changed to Bishop marking him the first to use the title in the Bishop. He was also re-elected for a further five year term from 1995-1999 to serve a total of ten years as the head of the church (Mujinga 2017:162).

⁸⁵ According to Shoko, "Fr Urayai of Chinyuni Mission in Chirumanzu District in Zimbabwe practiced spiritual healing from the late 1960s onwards. His healing practice was greatly shaped by a traditional religious worldview. The significance of his new style of healing in relation to the traditional context is comprehended in his personal history and vocation, his theology and healing ministry and social challenges and responsibilities" (2006:349). Two things come out clear if one has to analyse Shoko's argument. First, Fr Urayai started healing ministry in the Catholic Church in Zimbabwe at the same time that Mai Chaza, Mwazha and Manhango started theirs coming out of the MCZ. Second, although MacNutt's healing ministry theology became international, Fr Urayai's was the first to inculturate healing ministry in the Catholic Church in Zimbabwe and his contribution can be argued to have had an impact on the introduction of the theology of inculturation by the Catholic Church as it was introduced by Joseph Masson in Rome on the eve of the Second Vatican Council in 1962 (Bonsu 2005:19; Shorter 2006:11).

Third, the economic, political, social, technological, cultural and religious problems of America do not match the challenges of Africa in general and Zimbabwe in particular. Part of MacNutt's writing includes the role of faith, hope and charity as they touch upon the healing ministry, forgiveness, emotional healing, praying for the physical healing and deliverance and exorcism (MacNutt 1974). Given the socio-political change and turmoil Rhodesia went through, it could be justified with some reservation that the use of MacNutt's book was necessary since the context was not affecting Africans only but also the expatriates.

5.6 Healing Ministry in the Politically Independent Zimbabwe

The second step of taking evangelism as the first priority of the Methodist Church was introduced in the independent Zimbabwe in 1980. Zimbabwe gained its independence in 1980, and the theological landscape changed because both the Church and the country were now under African leadership. New evangelical approaches were inevitable. The dialogue between Christianity and ATR(s) was seen as a *sine-qua-non* by MCZ (Chirisa 1991). This dialogue was expected to answer the dilemma of the Methodist Church on its approach to healing ministry. The need to go back to the drawing board was emphasized by the then President (now Presiding Bishop) Rev Caspen Makuzva in his remarks to Conference. Makuzva argued that,

There is need for MCZ to start afresh, recommitting herself and reconciliation with each other if the church is to make a way forward. Jesus sends us now, "Go ye therefore" (Matt 28:19) start in Zimbabwe leave no stone unturned, evangelize person to person, mobilise everyone if you have twenty members, let each person do so, mobilise groups, stand in the streets, on paths, highways and by-ways also witness Jesus to all. Pray unceasingly... visit the lonely (Makuzva 1981: appendix 2).

In the same year, the MCZ Conference endorsed evangelism as the first priority of the church programmes (MCZ Minutes of Conference 1981). Evangelism was meant to revitalize the church from the turmoil that it had gone through. The evangelism programme was divided into two schemes, starting with the six year plan from 1982-1988, and the ten year plan from 1989-1999 (MCZ Minutes of Conference 1982:4). This approach was also an attempt to reconcile the mission of the church and African culture. The first phase experienced some major challenges during the implementation process. According to Madhiba, MCZ relied on foreign literature as discussed earlier, implying that healing

ministry remained foreign. Second, there were disagreements on means and ways to integrate Christianity and African Traditional Religion in the struggle to redefine the theology of MCZ in the independent Zimbabwe. This point was emphasised by Mabeza (who was the Vice President) (now Connexional Lay President)⁸⁶ in his Address to the 1981 Conference. He highlighted that,

There is need for research into African religion and culture. It is no exaggeration to state that almost all nations in the world find it difficult to understand Christianity when it is presented to them in the context of foreign environment and culture. Zimbabwe is not an exception. By definition, religion is part of the people's environment. Therefore it is necessary that adaptations are made in Christian religion, the purpose being to harmonize and blend the best elements of the African religion and culture with Christian religion (Mabeza 1991: appendix 3).

Some felt the programme was not realistic while others just participated in the programme. This scenario of disunity made the evangelism programme to be identified with a few individuals. Third, evangelism programmes brought confusion as the Church tried to reconcile the two approaches, one exclusive and militant, and the other tolerant towards other religions and cultures (Madhiba 2000:65). Some MCZ members who had passion for evangelism were given labels as anti-progressive. Still other people became unpopular, being referred to as *ve-evangelism* (those of evangelism). Healing ministry through these evangelistic approaches never appealed to the Africans.

Madhiba bemoans the lack of confidence in terms of clarifying the mission of the church that hampered the first phase (2000:65). The failure by the church on evangelism was also its failure on the healing ministry because healing is central to the task of evangelism. According to Maddocks (1981:13), Jesus's ministry made healing central, and throughout the New Testament, healing was integral to the life and work of the apostles. Fr Wermter (1989:3) argues that illness is a manifestation of deeply disturbed relationships and healing is an overcoming of adverse spiritual forces, restoring peace and becoming reconciled.

The second phase of the Evangelism programme started with a book called the *Missioners Training Manual* published in 1989. The manual was contributed to by both Methodist ministers and lay people. The manual was written in order to implement what the Church

⁸⁶ The Connexional Lay President means the lay person who presides over the Lay Session of Conference (MCZ *Deed of Church Order and Standing Orders* 2007:30).

had named “Simultaneous Mission” (Masvanhise and Sankey 1989:5). This was an Eight Days evangelism programme at one place with the same participants. Writing in the introduction of the book, the Conveners of the Evangelism Programme Revds. A.P. Sankey and Morris Masvanhise, the Evangelism Committee Secretary, argued that the period of Simultaneous Mission was aimed at reaching 1200 preaching places of the Methodist Church in Zimbabwe between 1989 to 1990 (1989:6). They also stated that another evangelical thrust would be introduced in 1991 with emphasis on the personal witness of each Christian and upon church planting. Many clergy members and lay people were trained as Missioners⁸⁷, to serve as facilitators in the Eight Day mission (Chirisa 1991:185).

The Missioners’ manual focused on teaching and sermon outlines for evangelistic preaching, the preparation for preaching, commitment, the life of a missionary, the prayer ministry in and for the missions, healing ministry in missions, introduction to class meetings, and mission preparation (Masvanhise and Sankey 1989:1-57). *The Missioners Training Manual* had two training programmes. The first *Eight Day Mission* programme focussed on the fundamentals of the Methodist faith: theological doctrine of God, Jesus Christ, Holy Spirit, man, and topics such as grace, faith, tithing, and healing. The programme included going in the villages to preach and offer healing ministry through prayers. After the healing programme outreach, the Missioners would report on their experiences. The programme included a day of compulsory fasting in order for participants to “receive the gift of healing”. The concluding day focussed on revision of courses taught during the past week (Masvanhise and Sankey 1989:52-53).

The second programme was a three-day Refresher Course for the trained Missioners that included a healing service for two hours on Saturday night. During these services Matsikiti claimed that people were expected to confess their sins because without confession there was no healing. Repentance and confession were regarded as the keys to unlock the healing ministry (2016). Heron (1989:48) argues that in healing ministry, people always need repentance and that repentance ends with sacraments of reconciliation. Although Heron defines repentance from an RCC theological perspective that included cleansing, cleaning and liberating life giving and joyful moment of forgiveness (:48), during the healing

⁸⁷ According to the Six-year Evangelism thrust, the Missioner was regarded as the opposite of missionary who goes to other countries to spread the Gospels. A Missioner is an African preaching the Good News to a fellow Christian in his or her neighbourhood (Masvanhise and Sankey 1989:36).

sessions conducted by the Missioners, repentance and confession were supposed to be done privately with ministers and those involved in witchcraft activities would bring their fetishes⁸⁸ to the altar as evidence that they have repented from that former lifestyle. One of the reasons for such an action was to maintain the integrity of those who confessed privately before the minister. The other justification would be that since the programme was at its initial stages, it was dangerous to publicize the ills of individuals because that was tantamount to dividing the church.

According to Matsikiti, one person confessed that she had *shave* (spirit) – the spirit of witchcraft – and each year there is a ceremony that is conducted as the lady will be recruiting more members in the cult (Matsikiti 2016). The Methodist Church member instructed that the *shave* must not be removed because her family will not be happy given that they were respected in the community (Matsikiti 2016). According to Wermer (1989:9), “healing is a sign that signifies in a tangible manner what the Kingdom of God means and restores the human person both spiritually and physically to wholeness once it is fully established. This sign of healing presents a glimpse of that final act of complete salvation and redemption when scripture promises that God will wipe away all tears from the eyes of people who believe in him” (1989:9). People who confess the sins, according to MacNutt, symbolically raise their suffering to the level of the cross, the level where they must learn to accept pain and not try to escape it (MacNutt 1988). The suffering that is caused by sin will bring redemption and healing when humankind seek not to pray to be freed from the pain of the current sin, but rather seek the royal road to the cross.

In order to acquire healing, Matsikiti claimed that people would bring their witchcraft agents wrapped in big sacks that were tied and then burnt at night at a big bonfire made by the community. No one was allowed to open the sacks before they were taken to the fire. At times the burning of those accused of witchcraft would involve unexplained phenomenon of some things bursting and some of the victims advising the ministers performing the burning ritual not to face the direction of the smoke because of the possibility of being contaminated by evil (Matsikiti 2016). This exercise was controlled by the church but lacked the necessary transparency through which to verify the authenticity of the events. For example, the persons that brought fetishes to be burnt never made known what the identity

⁸⁸ Fetish is an idol, an image or an object, believed to have supernatural or magical powers. It is associated with witchcraft and sorcery (Onyinah 2002:111; Walker 2015:133).

of the fetish was and for what purpose it was used. Indeed, some church members even accused the church authorities of favouritism to the families and friends that brought their witchcraft juju to be burnt but did so without the necessary requirement of confession (Matsikiti 2016).

The submission and burning of the witchcraft tools was also included in a healing process. The healing ministry was managed by the Evangelism team which was organised through leadership selected from the different districts or circuits (Matsikiti 2016). However, the ministry was not successful because some ministers refused to send their members to be part of the healing ministry and those that participated did not share their experiences with their home circuits. The Eight Day Evangelism programme had impact on the life of some ministers who had developed a smoking habit and were convinced to abandon the habit (Matsikiti 2016). The healing ministry in general was structured within the mission of the church and became an integral part of the how the Gospel of Christ was understood and communicated to the people seeking healing from Jesus (1989:46).

5.7 Challenge of Healing Ministry Strategies of MCZ after 1980

In general, the healing ministry strategy employed by the MCZ lacked an African theology of healing. This situation was exemplified within the Kwenda Circuit where African Methodist leaders like Mai Chaza, Mwazha and Manhango were excommunicated because of MCZ's failure to inculturate their healing ministry. For the overview of healing ministry after 1980, attention is given to dissenting voices within the MCZ that advocated for the inculturation of healing ministry, namely, Rev Claudius Matsikiti and Mr Eden Chombo. This section argues that MCZ's contradictory approach to inculturating the healing ministry limited its effectiveness among its own local people. The two leaders will be examined to illustrate this contradiction.

5.7.1 Claudius Matsikiti and the Formation of the Harvest Apostolic Ministry

Claudius Murau Matsikiti was a Methodist Minister from 1978 to 2004. He served in many capacities that included being a Superintendent Minister of both rural and urban circuits, Connexional Evangelism Director for seven years, and also the Bishop for Harare West District for three years. Matsikiti resigned when he had served as a Superintendent Minister for Wesley Circuit in Bulawayo from December 2003 to 28 January 2004 (Matsikiti letter

to Bishop Mukandi 2004). The resignation of Matsikiti from MCZ itinerant ministry is very important in this missio-cultural study because he worked in Mbare Circuit as Superintendent Minister and also worshipped at Mabelreign Society for three years when he was the Bishop of Harare West District (Matsikiti 2016). In his letter to the Bishop (Now Presiding Bishop) Rev Cephas Mukandi entitled, *Early Retirement/ Resignation*, dated 28 January 2004, Matsikiti wrote that:

...sir, I write to notify you of the decision I have made of taking early retirement from the Methodist Ministry. I was stationed in Wesley Circuit, I thought I was going to serve for at least three years at most. But because of the call to the 'new ministry' I was instructed to do has come to me forcefully so much that God would want it done soonest. I am going to run a kind of an Evangelistic Ministry called Harvest Apostolic Ministries (HAM). The call for this ministry came in 1988 and I was waiting for God's instruction as he promised. The warning instruction came in 1997, 1999 and by 2001, I was taken to another level and this year the final instruction have come and I have obeyed... I would prefer to be recognized as a Methodist Minister if the church accepts it... Harvest Apostolic Ministry aims to conscientising and motivating churches to transition from pastoral mentality to apostolic mentality... the details of the church can be shared with you and the church if you are interested (Matsikiti letter to Bishop Mukandi 2004).

Matsikiti further claimed that God had bestowed upon him the gift of healing the sick and to cast out of demons, that many people would come from different places to seek healing from him, and that he must trust God for everything because failure to do this would result in God withdrawing the gift from him (Matsikiti 2015:23-24).

In taking steps towards the formation of his ministry, Matsikiti was re-baptized by Rev Clifford Taylor⁸⁹ at the Victoria Falls, Zimbabwe (MCZ Minutes of Conference 2004:3, 29). According to the *Deed of Church Order and Standing Orders*, baptism in the Methodist Church is a sacrament that is administered only to those who had not previously received that rite (2007:4). Matsikiti, by taking a decision to be re-baptized, went against the MCZ theological understanding and practice of this sacrament. However, one would argue that the rebaptism of Matsikiti was a challenge that should have required MCZ to reconsider its theology. The Methodist Church Conference found grounds to remove Matsikiti from the Methodist membership and the clergy. However, at a later date, Matsikiti stated that his exit

⁸⁹ Rev Clifford Taylor was a Methodist Missionary from Ireland who was stationed as Superintendent Minister of Mutare Circuit.

from the Methodist Church came through expulsion and not resignation.⁹⁰ He took the MCZ to the Secular Courts (Gonese, Jessie Majome and Company 2011) to prevent the church from expelling him from the ministry. Matsikiti's letter of resignation contradicted his legal case in which he indicated that he had received a call to the new ministry of healing. He also requested the church to take his decision with the same spirit that he had (Matsikiti 2004). In 2011, his lawyers wrote to the General Secretary of MCZ, Rev Dr. Ananias K. Nyanjaya, stating that:

We request that you furnish us with disciplinary hearing records or any other related documents of Mr. Claudius Matsikiti that pertains to the reasons for his departure from your organization. Please be advised that failure or refusal to release this information is tantamount to being in contempt of court. Our request is guided by an order of court and this evidence is necessary for justice to be met (Gonese, Jessie Majome and Company 2011).

Matsikiti wanted to be free from the Methodist governmental authority to operate his own healing ministry but also wanted to remain in the Methodist ministry that would give him theological and social respectability and authenticity. Matsikiti was not the first Methodist leader who wanted to remain clinging to the Methodist Church membership and title after being expelled or having resigned. In the same manner, Mai Chaza continued to wear the Methodist Ruwadzano uniform, Mwazha called himself a Methodist, and Manhango used Methodist theology and uniforms. Basing on these examples it could be argued that the advocates for independent healing ministries were not willing to pay the full price for their independence. They still craved for the social and theological benefits of belonging to the MCZ family. This point is justified by the statement in Matsikiti's letter which says, I will accept any decision the church arrives at concerning my affiliation to the Methodist Ministerial body. If I were given a choice, I would have loved to be one of them though not actively involved in church discipline as them. I shall serve faithfully in Wesley Circuit up to the end of 2004 (Matsikiti letter to Bishop Mukandi 2004).

5.7.1.1 Matsikiti's Understanding of Healing Ministry

According to Matsikiti, illness is demonic and people must be freed from all forms of problems. Healing ministry aims to deliver people from burdens caused by physical,

⁹⁰ Matsikiti wrote a letter tendering his resignation from MCZ explaining his new call to the new ministry. However, in his letter dated 28 January 2004, he requested to remain benefitting from the MCZ system although not serving it (see Matsikiti personal File).

spiritual or even emotional ill-health (Matsikiti 2016). The appreciation of healing ministry by Matsikiti can best be understood from the crusade that was conducted in August 2000 by the Marondera District in Mutare that was sponsored by Rev Clifford Taylor. It could be argued that this crusade became the launching pad for Claudius Matsikiti, Eden Chombo and Jacob Muguraguri to form their independent churches (Makwara⁹¹ 2016). Chombo will be discussed later in this chapter given that he was once the District Vice Chairman for Marondera District (now District Lay President); however there is less information available on Muguraguri who was a lay member of Marondera Circuit.

According to Matsikiti, the aim of every member in the church is to be freed from his/her sickness. If the church cannot meet the needs of the people holistically, that church should cease to exist (2016) because the church as the body of Christ is intended among other things to be precisely a place where people should have access to healing. The church is therefore a nursery for nurturing new Christians, a training and teaching institution for discipleship formation, an army in the battle with the powers of evil, and a hospital for the wounded or the damaged and battle-wounded (White 1993:240). Matsikiti claimed that MCZ was the first to take an initiative on healing ministry as compared to other mainline churches. This advantage was brought by the Church's introduction of the Evangelism department. But it was not consistent with its theology of healing because MCZ was too rigid to be a modern church that wants to practice an authentic healing ministry (2016). Matsikiti concluded that Mai Chaza, Manhango and Mwazha operated their healing ministries outside of the Methodist Church polity and they suffered the wrath of the church; he did not want to repeat this. Matsikiti argued that when the British missionaries established the MCZ, they set a standard of belief and practise that was made to be normative for all members of the church (2016), and which gave priority to the medical rather than the supernatural and spiritual. This kind of healing method was done by simply offering general prayer for the sick, and only the clergy and the evangelists, not the laity, were authorised to carry out the healing rite. A case in point was the controversy of Manhango who was disciplined for engaging in healing rites, being a lay person. Matsikiti points to tension over power and authority as the reason for the MCZ preventing the layperson from exercising the healing ministry – because

⁹¹ Rev Seaward Makwara is the Superintendent of Highfield Circuit in Harare West District. During the time of the said crusade, he was the District Synod Secretary of Marondera District. Synod Secretary, according to the Methodists, is an administrator of the District affairs. He also became the Bishop of the same District for five years.

of fear that they would undermine the authority of the minister in healing ministry – which was deemed to be a serious crime in the clergy-centred Methodist Church (2016).

There was division between African knowledge systems and western medicine on diagnosing and treating illness. For example, according to Pobee, what is diagnosed by western medicine as a stroke can be diagnosed by a traditional African healer as a curse of the ancestors on the member of the clan (2001:48)? What was diagnosed as an ulcer or diabetes or alcoholism is often attributed to evil and witchcraft among the Africans (2001:50). Matsikiti states that missionaries were able to detect physical and emotional illness but not spiritual ailments (2016). It is against this background of the failure of western colonial leaders to understand the African approach to diagnosing illness that they introduced the *Witchcraft Suppression Act* as a method of discouraging the embrace of the African worldview on health (Matsikiti 2016). According to Mwandayi, “the passing of the Bill, *Witchcraft Suppression Act* in 1899, was yet another design by the colonial government to suppress the activities of traditional healers” (2011:232). The missionaries and the ministers of the time did not believe in witchcraft and sorcery. During the evangelism programmes led by Matsikiti, the Methodist Church’s thrust was that a person can become ill physically, spiritually or emotionally. The physical aspect is rooted in the demonstration of an externally moral lifestyle that rejects prostitution/ fornication, beer drinking and smoking. Physical problems are therefore the cause of physical diseases. Emotional illnesses are triggered by internal weakening of defence mechanisms, and spiritual illnesses are associated with attacks from life denying non-physical beings. “In Methodist theology a Christian must be filled by the Holy Spirit in order to be equipped in overcoming physical and emotional problems through illness” (2016).

In his new healing ministry, Matsikiti condemns and regrets all that he did when he was still a Methodist member, citing that MCZ thwarts those called by God to healing ministry. He argued that Jesus never prayed for anyone to be healed (2016). Kelsey agreed with Matsikiti and stated that, Jesus’ method of healing was quite varied, such as calling upon the sick to exercise faith, speaking words and touching people with his hands, using resources such as saliva, mud, and possibly oil (1973:79-80). For Kelsey, Jesus healed people because of three reasons: first, he cared for them; second, he was hostile to what made them sick; and third, he wished to bring them to repentance for their sins and conversion to the kingdom (:79-80). Matsikiti’s understanding of healing has to be approached with a critical lens because

in spite of his claim to great faith in his new healing mission, his wife suffered a stroke that he was unable to heal. Matsikiti, who claimed that he used the healing methods of Jesus that commanded the sick to be healed, was unable to practice what he taught, in his own house.

5.7.2 Eden Chombo and the Revival Fires Apostolic Church

Eden Chombo was a member and lay leader in the Chimbwanda East Methodist Church in Zimbabwe. This church is located in the community south of Harare and west of Marondera. Chombo served also as local preacher, Circuit Steward of Nenguwo Circuit which is now divided into Nenguwo and Chihota Circuits (MCZ Handbook 2016), and as Marondera District Stewardship Coordinator where he was involved in the programmes together with Matsikiti. In addition, he also served as the Vice District Chairman (now District Lay President) for Marondera District from 1995-1996 then 2000-2004. The second term of his office is what is crucial in this missio-cultural research – when Rev Chikwape⁹² was the Superintendent Minister of Nenguwo Circuit. The clergy leadership in Marondera created fertile ground for the emergence of healing ministry by Chombo within the Methodist Church and later when he had formed his own AIC called Revival Fires Apostolic Church (Chikwape 2016; Gerema 2016). In order to understand these synergies, the next section will explore the Mutare Crusade (Tunnel of Fire Revival) of August 2000.

5.7.2.1 The Mutare Crusade August 2000

The crusade took place in the Mutare Show Grounds with Rev Taylor, Rev Matsikiti and Mr Chombo as leaders. People came from different circuits of Marondera District for the healing mission in Mutare, with the blessing of Rev Masimba Takawira, the District Bishop (Makwara 2016). Over ten thousand Methodist members and non-Methodists attended the four day's crusade. Taylor claimed that people could receive the Holy Spirit of God when

⁹² Rev Chikwape Chikwape is the current Superintendent Minister of Ngezi Circuit. He was the minister in Nenguwo Circuit when Chombo started his Church. It started as a prayer group and he was at one time part of this prayer group that met on Mondays. It was easy for the minister to be attracted to be a member in the Bible Study group because administratively, Chombo was senior to Chikwape as the District Vice Chairman. Chikwape worked with Eden Chombo for five years and during the first days, he was moving together with Chombo. Later, the former friends became enemies when Chikwape disciplined Chombo, the District Vice Chairman with an On Trial status, a situation which is rare in the Methodist Church. Controversially, Chikwape's young brother joined Revival Fires Apostolic Church. Each time he would go to this church, he was coming from the manse and from his brother who disciplined his "bishop"- Chombo.

some anointed leaders lay hands on them (Chikwape 2016). According to Taylor, after receiving the “spirit”, one should start to “prophecy” (Makwara 2016). However, there were some conflicts between the two healers, Matsikiti and Chombo, because Matsikiti had his own way of healing and he wanted Chombo to join him since he was a layman (Chikwape 2016). Chombo was not prepared to take this action since he thought that he was more anointed than Matsikiti. After the crusade, the two men parted ways, with each forming his own movement, one African Initiated and the other Pentecostal in nature.

5.7.2.2 Eden Chombo’s Understanding of Healing Ministry

The healing ministry of Chombo came from a different theological perspective. In comparison to other dissenters, he was the first lay leader with an influential position to officially move out of the Methodist Church to form his movement. Mwazha was an Evangelist whereas Mai Chaza and Manhango were ordinary lay people, and Matsikiti was a minister. Chombo argues that there is nothing that God cannot do for someone to be healed. He also believed that God works through people but the gift of healing is for the selected few who are either ministers or lay people (Chikwape 2016). In the researcher’s own analysis, it is probably this understanding that made Chikwape to sit and listen to Chombo leading a group that eventually became a church. Chombo also stated that when God speaks, only the one whom He is speaking to can understand or hear God’s voice (Gerema 2016). Chombo argued that healing should be done by laying on of hands only by the chosen healers. These healers have the power to appoint other healers. Interestingly, Chikwape’s young brother left MCZ to join the Revival Fires Apostolic Church and this became a conflict of interest at his workplace and with his family (Chikwape 2016).

Chombo maintains that the anointed healers would do the job but his healing was different from others healers. Chombo used the AIC prophetic style of telling people their problems. He claimed that he would detect a demon from the eyes of individuals, a claim that is common among some MCZ contemporary ministers. Chombo was noted for his healing sanctuary and tower (his meeting point with God) where he engaged in prayers and healing services (Chikwape 2016). He possessed a sacred cross that he inherited from his step-father who was the leader of an African Apostolic Church in Zambia where he died (Chikwape 2016). Being the eldest in the Chombo family, Eden Chombo received the cross, white gown, the Bible and the rod since he was now the heir of the family (Chikwape 2016). The family members advised him that the mantles were going to empower him like his step-

father. He wore the gown while he was a Methodist Local Preacher, however, the Methodist Church did not allow local preachers to wear gowns, especially because the white ones resembled those of the African Initiated Churches (Chikwape 2016).

Chombo's healing methods involved using either red or white cloth facing the green cloth, with a cross, whilst praying for people. He believed in dreams and as people narrated their dreams he would follow up with the individual to determine the meaning of the dream. Chombo's healing methods included the use of Ruwadzano/ Manyano belts on the head of those whom he suspect to be demon possessed. His ministry had a serious impact on the life of Nenguwo Circuit (Chikwape 2016). First, a song was composed that mocked the Superintendent Minister Rev Chikwape who had disciplined Chombo. The song was sung as "*Chikwape rega mweya utenderere* (Chikwape leave the Spirit to do its work). Second, the healing ministry divided families, e.g. the husband would remain in the MCZ and the wife move out to Revival Fires Apostolic Church or vice versa. Other examples include the family of the Superintendent Minister of Nenguwo as argued earlier. Chombo believed in confession of all the sins of the past life; however some confessions would disturb the families because they were very emotional. For Chombo, confession was a way to weaken the demons. It is very imperative to note from these discussions that although Revival Fires Apostolic Church did not last long after Chombo's death, his influence had marks in Nenguwo and Mbare Circuit because some of the youth of his group were coming from these circuits.

Before leaving the Methodist Church, his group would dress in white like *vapostori* (African Initiated Church adherents) and he would not shave his hair (Chikwape 2016). In the course of time, Chombo had an interpreter because He would speak with a low voice and the interpreter would shout to the people 'the message from God' (Chikwape 2016). People could come from distance places like Mutare to be healed by a gifted Methodist who was also the District Vice Chairman. After Chombo died, his Revival Fires Apostolic Church was fragmented into three groups⁹³ (Chikwape 2016). The leaving of these Matsikiti and Chombo in the post-missionary MCZ shows that while localization has taken place, it has been more in terms of leadership rather in terms of theology of healing. It seems MCZ's

⁹³ The original Revival Fires Apostolic Church is being led by Bishop Gamuchirai Gerema, a former Methodist youth leader and a Local Preacher at Chakadini Methodist where Rev Chikwape was a minister. Gerema moved out of MCZ with a bigger number of both youth and adults at Chakadini MCZ when the new indigenous church started from a Bible Study group that was led by Eden Chombo.

theology of healing continues to reflect the missionaries' position. The MCZ not only dealt with faith healing, but also went further to care for the physical body. The church introduced healing ministry to the people living with HIV and AIDS.

5.8 Healing Ministry to HIV and AIDS in the MCZ

Among the healthcare challenges that came with the independent Zimbabwe was HIV and AIDS. The pandemic came as a social, political and economic challenge but had a theological implication since the church was not spared. The rise of HIV and AIDS was not unique to many countries. According to Chitando, although research indicates that HIV and AIDS occurred earlier, it was only in the 1980s that most governments acknowledged it (2007:1). This is the same time Zimbabwe got its independence. Effectively, the country got independence but inherited a pandemic that has come to stay (Chitando 2007:1). There are many debates surrounding HIV and AIDS in Africa, with scholars such as Chirimuuta and Chirimuuta arguing that publications defended African integrity by means of conspiracy theories claiming that HIV and AIDS were the result of a plot of outsiders to eliminate blacks (1987). Other Africans described AIDS with casual and dismissive attitudes, interpreting it as American Ideas to Discourage Sex (Chitando 2007:1). This section will discuss the role that was played by MCZ in the healing ministry of HIV and AIDS with the aim to find out whether the Church was relevant to its mission to the needy. The section will start by giving a general definition of HIV and AIDS then proceed to give a brief analysis of HIV and AIDS in Zimbabwe.

5.8.1 General Introduction to HIV and AIDS

There are many works on HIV and AIDS and it is not within the scope of this research to provide a detailed scholarly argument on this topic. A general definition will be provided in order to link the research to the challenge that the Methodist Church faced with HIV and AIDS. The impact of HIV and AIDS on Africa was expressed by Edwin Cameron, a South African High Court judge who was living with HIV and AIDS. Cameron argued that:

HIV is simply a disease and yet much more than a disease AIDS is not a disease. It a disorder, an infection, an illness, a syndrome, a condition threatening to human life, it is an epidemic - a social crisis, a political challenge, an economic catastrophe, a human disaster... AIDS is stigma, disgrace, discrimination, hatred, hardship, abandonment, isolation, exclusion, prohibition, persecution, property privation...it

is made moral. It is punishment, deterrent, retribution, sin, a lesson, a curse, condemnation rebuke, judgement. It is a disease (2005: see also Mujinga 2012: 206).

All the words used by Cameron to describe HIV demonstrate that it is more than just an illness. This is the kind of challenge that African countries inherited upon their independence. In its definition, HIV stands for Human Immunodeficiency Virus (Chitando 2007:1). These viruses cause many scientific diseases such as measles, hepatitis A, B and C, chickenpox, polio and rabies (Chitando 2007). The virus is only found in the human body; immunodeficiency means the virus reduces the defence power of the immune system which has the job of protecting the body from all kinds of infections (Igo 2009:15). HIV enters the very cells that should provide the source of healing and silently burrows its way into a person's life, reproducing itself as an evil substitute, destroying people from within (2009). The body's defence systems will be worn out and this allows many different infections to enter the body and destroy it (2009).

In Africa, AIDS has been interpreted in different ways by many people as they wish to express how deadly the disease was. Garland and Blyth argue that the word has caused confusion in the minds of some people, with some people referring to it with different negative terms (2005:24). In Zambia, it was referred to as 'keys to the mortuary' "while in Zimbabwe, some named it 'Lord here I come' (2005:24). However the actual meaning of the abbreviation is Acquired Immune Deficiency Syndrome. Acquired disease means the one that someone can have through person to person transmission. HIV and AIDS was a social issue, and it was also political because of the poor governance of African leaders. The fact that HIV and AIDS was non-selective made the health issue to later become an economic and theological issue. Unfortunately, according to Dube, "since the coming of HIV and AIDS, the church did not dare to be involved in the debate about the pandemic and the fight against it claiming that it was God's punishment for the immoral" (2003:1).

5.8.2 A Brief Analysis of HIV and AIDS in the Independent Zimbabwe

The first reported case of AIDS in Zimbabwe occurred in 1985, just five years after Zimbabwe gained independence (Chitando 2007; Mboma 2002; Mujinga and Moyo 2016). "By the end of the 1980's, around ten percent of the adult population was thought to be infected with HIV. This figure rose dramatically in the first half of the 1990's, peaking at 26.5% in 1997" (United Nations General Assembly 2010). According to government figures, the adult prevalence was 23.7% in 2001, and fell to 14.3% in 2010 (United Nations

General Assembly 2010; Mujinga 2012:99). “The collapse of the health delivery system necessitated the spread of the pandemic. The Zimbabwe demographic and health survey showed that around 76% of women and 86% of men knew that condoms could reduce the risk of HIV infection” (The Herald 2 November 2007). However, the Church insisted that the use of condoms does not make the sexual sin better. The church preached abstinence, but not everyone was listening to the church’s gospel (Garland and Blyth 2003:201). As a result, the church became a stumbling block on HIV and AIDS. Culturally, HIV was exacerbated by the fact that stories about sex are taboo in Africa; as such, the church, being African, also turned a deaf ear to the pandemic (Chitando 2007). The church actually played a condemnation game with the infected.

When HIV and AIDS were first discovered in Zimbabwe, the government was slow to acknowledge the problem and take appropriate action. Discussion of HIV and AIDS was minimal (Chitando 2007). Although the National AIDS Co-ordination program was set up in 1987 and several short term and medium AIDS plans were carried out over the following years, it was not until 1999 that the country’s first HIV and AIDS policy was announced (Mujinga 2012:100). This was almost 14 years after the pandemic had killed a number of people, with stigma and discrimination being the major negative forces. This policy was implemented by the newly formed National AIDS Council. In an effort to curb the pandemic, the government introduced an AIDS levy on all tax payers to fund the work of the NAC (Chitando 2007). While these measures have had a positive impact, the government’s response to HIV and AIDS has been ultimately compromised by numerous other political and social crises that have dominated political attention and overshadowed the implementation of the National AIDS policy. The NAC has also been constrained by poor organization and a lack of resources. The efforts of preventing HIV in Zimbabwe have been spearheaded by NAC, non-governmental, religious and academic organizations. Prevention programs aimed at behaviour change and prevention of mother to child transmission have been instrumental in bringing about a decline in HIV prevalence (Zimbabwean Report of the Fact Finding Mission to Zimbabwe to Assess *Murambatsvina* 2005).

“In 2006, the Ministry of Education, Sport and Culture, partnered with UNICEF and initiated an in-service training scheme of primary and secondary school teachers in HIV and AIDS life-skills and counselling” (Chitando 2007). Outside school, efforts to educate and

inform the people about HIV and AIDS used a number of means to convey prevention messages, including television and radio, drama and community groups. A combination of stigma and discrimination associated with HIV and AIDS was a great barrier to preventing further infections and providing adequate care, support and treatment. The combination also resulted in the failure to access services and exacerbated human suffering such as loss of employment, rejection by family members, denied marriage, quarantine, and abuse (Chitando 2007; Mujinga 2012:102). Despite the level of awareness, HIV and AIDS remained highly stigmatized in Zimbabwe. People living with HIV are often perceived as having done something wrong, and discrimination is frequently directed to both the patient and their families.

Many people were afraid to get tested for HIV for fear of being alienated, losing their partners, or losing their jobs. Those who know their status rarely make it publicly known, which often means they did not have access to sufficient care and support. Various attempts have been made to improve the situation, such as the 2005, ‘don’t be negative about being positive’ campaign (Chitando 2007). This campaign encouraged people to reveal their HIV positive status and to share their stories. The organizers won the 2005 Global Award for their work (All Africa, Zimbabwe: Rural Children with HIV Lost Cause 28 June 2010) but the church was not in a hurry to embrace HIV and AIDS (Dube 2003:1). Further readings about HIV and AIDS can be accessed from the works of Chitando (2007a, 2007b, 2009), Dube (2003), Parry (2008), Igo (2005) and Chirongoma and Chitando (2012). At this point, it is essential to assess the role of the MCZ regarding the healing needs of the people living with HIV and AIDS.

5.8.3 The MCZ’s Engagement and Disengagement on HIV and AIDS

Whereas the first case was identified and acknowledged in 1985 (Mboma 2002; see also Mujinga and Moyo 2016), both the government and the church entered into a state of denial (Hove 2013:7). According to Pastor Maxwell Kapachawo,⁹⁴ the church has been spending more time burying its members than baptizing them because of its silence on HIV and AIDS (Mlambo and RelZim Staff 2012). When the churches finally recognised the urgent need to

⁹⁴ Pastor Maxwell Kapachawo was the first pastor to declare himself to be living with HIV and AIDS in Zimbabwe.

respond to the HIV and AIDS challenge, Tanyanyiwa⁹⁵ observed that MCZ was the first denomination to establish a fulltime office of HIV and AIDS Coordinator. However, Tanyanyiwa (2011) lamented that the development of health services in the MCZ has been slow because it had taken on a reactionary approach for a long time; and it only became active because it could no longer be neutral when so many of its own people were suffering. This slow response to health issues facing the people seems to be part of the MCZ missional apathy because an earlier crisis in 1916 led to the closure of the local hospital. Tanyanyiwa argues that when HIV and AIDS was publicized, the church was never perturbed and it was both blind and deaf to the whole process (2011) until fifteen years later when HIV became a pandemic and had caused untold suffering and death in Zimbabwe and in the Church. The reluctance by the church to discuss sexual matters in Africa is mostly driven by the fact that sex stories are a taboo (Dube 2003). Nevertheless, when the church chose to get itself involved, it was with half a heart, fighting HIV with no resources, with very little commitment and effort, and allocating it very little time (Tanyanyiwa 2011).

The MCZ established its HIV and AIDS unit in 2000 with the mandate to implement all health programs incorporating awareness and education of diseases, prevention, mitigation and care. The other aim of the establishment of the HIV and AIDS unit was to promote peer education, conduct training on HIV and AIDS, and Home Based Care programmes (Tanyanyiwa 2011). The MCZ partnered with the Centre for Disease Control, Africare, World Vision, Hospaz and many government and United Nations agencies in this programme (Tanyanyiwa 2011). Teams were appointed to all its districts, circuits and societies that would be working with the MCZ National HIV and AIDS Coordinator. In addition, the MCZ engaged in the training of its ministers on HIV and AIDS programmes. All the 116 ordained ministers in the Connexion were trained on HIV and AIDS awareness in 2010 (Methodist Development and Relief Agency website). The other drastic step taken by MCZ constitutes the Health and Social Services Committee at Connexional level (national), district, circuit and society (MCZ *Deed of Church Order and Standing Orders* 2007:70). Among the members of this committee was the Presiding Bishop and Mission Director (:70) who are key leaders in the daily running of the MCZ.

⁹⁵ Tichapiwa Elton Tanyanyiwa was the Health and Social Services Coordinator with the Methodist Church who resigned in 2012.

Apart from coordinating HIV and AIDS programmes, the coordinator was then given other responsibilities to monitor all health issues in the church, and his job description was upgraded to Health and Social Services Coordinator (Tanyanyiwa 2011). Surprisingly, from 2012, MCZ disengaged from the HIV and AIDS programmes following the resignation of the Health and Social Services Coordinator. Two years after the resignation, MCZ continues to bemoan the end of the donor community's support for its HIV and AIDS programmes (Mujinga and Moyo 2016:51). The Mission Director of the MCZ, Kennedy Gondongwe's report on HIV and AIDS states that: "though there seems to be dead-end the thrust of HIV and AIDS within the donor community, as a church we continue to attach great zeal and enthusiasm to this mission focus. As such we have assigned Methodist Drought and Relief Agency (MeDRA) to take over the issue of HIV and AIDS for the purposes of both planning and execution" (MCZ Minutes of Conference 2014:41). The same Minutes clearly indicated that HIV and AIDS programmes were no longer part of the Health and Social Services (MCZ Minutes of Conference 2014:42). An analysis of the phrase, "take over the issue of HIV and AIDS" indicated that HIV and AIDS had ceased to be a healing ministry agenda of MCZ but became just another "one of the issues" of MCZ. At the MCZ 2015 Conference, both the Mission Director's report and the MeDRA reports failed to report on HIV and AIDS programmes. The 2016 MCZ Agenda of Conference also had nothing to report on HIV and AIDS, both as an issue and as a programme (Mujinga and Moyo 2016:55). These developments seem to suggest that HIV and AIDS is no longer a priority in the MCZ. Again, a pattern seems to have developed that just like in Kwenda and Waddilove, the church, though challenged by the felt needs of the poor, will openly abandon its ministry to the needy when it is confronted with financial and leadership challenges.

5.8.4 Factors that could have Led MCZ to Disengage on its Healing Ministry of HIV and AIDS

It is not clear exactly why MCZ disengaged from its theology of the poor, even though the poor formed the greater part of John Wesley's theology. However, the socio-economic and political context within MCZ and the nation after 2000 may explain the factors that contributed to the disengagement with programmes on HIV and AIDS (Mujinga and Moyo 2016). According to Pausigere (2008), since 1990, 3 million Zimbabweans migrated to South Africa mainly because of the socio-political crisis, and by November 2008 the Zimbabwean annual inflation rate was 89.7 sextillion. McGreal comments that eighty

percent of Zimbabwe's population was living on less than one pound a day and nearly half were chronically malnourished (McGreal 2008). This period saw most Zimbabweans seeking healing, more than ever before. The Zimbabwean socioeconomic crisis did not change even after the introduction of the multicurrency regime that was meant to improve the availability of foreign currencies. According to Mangena and Mandizha, "the crisis was punctuated by mortality rate, a malfunctioned health system, high unemployment level, low industry utilization, salaries below poverty datum levels, a number of disease outbreaks" (2013:132). This dire economic condition within the nation affected the MCZ to the extent that the HIV and AIDS healing ministry proved too much for the church's budgetary support and was therefore abandoned even though it was supposed to be central to its mission.

Chirongoma (2006:175) mentions that the Zimbabwean health system used to compare favourably with most other countries in Sub-Saharan Africa. However, Mangena and Mandizha (2013:133) bemoaned the health situation in Zimbabwe as hospitals and clinics experienced shortages of staff such as doctors, nurses and other health professionals, and over a short period of time, life expectancy fell from sixty-five years to forty-three years in 2005. In 2009, it was estimated that sixty-nine percent of doctors' and eighty percent of midwives' posts were vacant (Mangena and Mandizha 2013). This socioeconomic situation had a serious theological implication for the church, MCZ in particular. This milieu caused a lot of despair and depression among the citizens (Chitando 2009:29). This situation was worse in MCZ because they neither had a competitive health institution nor any solution for its sick members. The socioeconomic and political crisis of this period resulted in an obsession with healing ministry that emerged within the public discourse because the community and family support system had been severely weakened and their effectiveness was compromised (Mujinga and Moyo 2016:54). The ministry and mission of the churches in Zimbabwe were also compromised because the same congregants were heavily affected by inflation that further weakened their economic status. Zimbabweans sought solace in Pentecostal churches for miraculous 'prosperity and health' solutions to their problems (Mangena and Mandizha (2013). Zimunya and Gwara maintain that in such a scenario of poverty and uncertain events, Pentecostal churches sprouted and offered much needed solace, especially with the healing of all ailments. These ailments would include HIV and AIDS. The drive toward mega-Pentecostal churches that was born during this period was necessitated by their promise to provide answers to the healing needs of Zimbabweans

(2013:190). This situation saw Methodist members practicing dual membership or completely transferring their faith to these churches (see also Mukonyora 2007:4).

5.8.5 The Impact of MCZ's Disengagement from HIV and AIDS Healing Ministry

Chitando argues that a church that understands Jesus will label itself as HIV positive (2007, 2009; Presbyterian Church (USA) 2010; Parry 2008; 2013; Moyo 2015). In view of this statement, the disengagement of MCZ from HIV and AIDS programmes demonstrates that the denomination had also disengaged its ministry from being faithful to that which was consistent with the ministry and mission of Jesus. Maddocks argues that “Jesus in his healing mission addressed the sick, touched them, smeared their bodies with oil, applied saliva and mud poultices to the diseased part of the body, address the individual’s faith and their prayer for thanksgiving and for the forgiveness of sins” (1981:60-61). In contrast, MCZ reports demonstrate that the denomination is no longer humble to be either like Jesus or its founder John Wesley in dealing with people living with HIV and AIDS. Chitando remarks that African churches need friendly feet to journey with individuals in communities living with HIV and AIDS, warm hearts to demonstrate compassion, and anointed hands to affect healing (2007:1). These characteristics of the church are no longer features of the contemporary MCZ, but of the time of John Wesley. The act of disengagement from HIV and AIDS ministry by MCZ therefore contradicts the point raised by Kalu that “healing is a heartbeat of liturgy and the entire religious life. It brings the community of suffering together, it ushers supernatural power into the gathered community and enables all to bask together in its warmth. It releases the energy for participatory worship that integrates the body, soul and the spirit” (2008:253; Mujinga and Moyo 2016:53).

The WCC states that the church is called upon to share the suffering of persons living with HIV and AIDS and open itself in this encounter to their own vulnerability and mortality (2005:100). According to Jarvinen and Virtanen (n.d:5; Mujinga and Moyo 2016:54), the church should be the first to bring liberation to all people, empower them, and erase the stigma which is associated with HIV and AIDS. Instead of causing stigma, the church must work actively and purposefully to take the side of the infected and sick people. The WCC further argued that “when the church properly responds to people living with HIV and AIDS, both ministering to them and learning from their suffering, its relationship to them will indeed make a difference” (2005:101).

5.8.6 People Living with HIV and AIDS: An Amputated Part of the Body of Christ in the MCZ?

The mission and mandate of the church has been compromised by its position on HIV and AIDS. People living with HIV and AIDS in the Methodist Church are like an amputated leg on the sportsperson (Mujinga and Moyo 2016:54). According to the WCC (2005), “the church’s response to the challenge of HIV and AIDS comes from its deepest theological convictions about the nature of the body of Christ and the reality of the Christian hope”. Whereas the WCC (2005) thinks that “the Church is a communion of ‘the body of Christ’ with many members that are distinct to each other (1 Cor. 12:24b-27)”, Chitando questions “what it mean to be ‘one body’ when some members of the body are living with and affected with HIV? How can the church claim to be the body of Christ when some of its members have to endure stigma and discrimination? Crucially, what is the mission of the church in the time of HIV and AIDS?” (Chitando 2009; see also Moyo 2015). Therefore it could be argued that MCZ is like a disabled body because of its ineffective response to the community of the people living with HIV and AIDS (Mujinga and Moyo 2016:54). Parry reports that one of speakers at the Evangelical Conference in 2008 stated that, “if your church does not address HIV and AIDS, your ministry is of little relevance today” (2013:3). Yet the MCZ, being a strategic ecclesial institution to which thousands of people give their allegiance, has failed to minister with fullness of life to people living with HIV and AIDS (Mujinga and Moyo 2016:54).

Parry mentions that in HIV and AIDS ministry, the church faces the biggest combined social, cultural, economic, medical and political issues, and at the same time, it deals with individual persons one by one - those infected by HIV and AIDS and their families much affected by it (2013:17). The MCZ’s vision to be “an oasis of life, peace, justice and hope” (MCZ Minutes of Conference 2015: ii) has failed to be actualised within the community of persons living with HIV and AIDS. A critique of this vision statement exposes MCZ to a denomination that is preaching Christ without living out his ministry among the most vulnerable people living with HIV and AIDS (Mujinga and Moyo 2016:55). By disengaging from ministry with HIV and AIDS, MCZ has betrayed its theological mandate of healing ministry (Mujinga and Moyo 2016:54).

Parry suggests seven reasons why the church should be involved in mainstreaming HIV and AIDS. First, people living with HIV and AIDS are in the church and the church should not

disengage from its call (2013:7). According to Moyo, some church members are infected by HIV but it is very difficult to disclose their status because of stigma (2015:49). This means that MCZ has not been spared by HIV and AIDS because its members are either infected or affected by HIV in one way or another. This suggests that MCZs disengagement equally split its members between those affected/infected and those completely free from HIV, which is technically impossible and worse self-deception (Mujinga and Moyo 2016:56).

Second, HIV is hurting people by destroying relationships. It has divided families and communities (Parry 2013:7). Parry states that HIV has created generations of largely disadvantaged orphans and children whose lives are severely compromised due to the insidious and overt impact of HIV on a household's ability (Parry 2008). She further argued that HIV is unlike other challenges faced by the church because it strikes at the very core of relationships, and its impact is chronically deadly (Parry 2008; Mujinga and Moyo 2016). For Parry, "the response of the HIV competent church to the pandemic should be characterized, both in the life of the church and in the lives of those who serve in this field, by the fruits of the spirit, love, joy, peace, patience, kindness, goodness, gentleness, fruitfulness and self-control" (Parry 2008). If Parry's analysis is correct, then it is questionable what kind of gospel MCZ is preaching if it disengages from HIV and AIDS programmes that are the centre of conflict among the church members. Being an HIV active church means being a healing church and being a healing church means belonging to the body of Christ that offers caring for people who are denied fullness of life.

Third, Parry comments that "the church should be involved in HIV and AIDS because it has a competitive advantage to secular interventions" (2007). According to Garland and Blyth, "the church in Africa is in a uniquely key position to address most of the aspects of the HIV and AIDS pandemic" (2005:278). The two scholars contend that the church has an extensive reach and its influence filters through most African communities where it has an untapped potential to successfully reverse the cause of the pandemic (:278). There, MCZ is mandated to engage and not disengage on HIV and AIDS.

The fourth point states that the church is already involved in development and humanitarian programmes and linkage between these and HIV and AIDS are development gaps which the church should well recognize (Parry 2013:7). Chitando supports this point by suggesting that the church in Africa is undoubtedly a significant presence in the social-political,

economic and spiritual lives of the people and is therefore strategically placed to make a difference in the context of HIV and AIDS (Chitando 2007:5). MCZ is not an exception and should awake from its slumber by welcoming and reintroducing the HIV and AIDS programmes. Chitando uses the word *compassion* to describe an HIV and AIDS competent church. In his definition of compassion, Chitando argues that the church should feel pity for people in different circumstances (Chitando 2007:54). However, compassion in HIV and AIDS does not mean that the church should feel pity for them, but stand in solidarity with them. MCZ, having abandoned HIV and AIDS healing ministry, has cut-off a part of its body (Mujinga and Moyo 2016:57). Chitando concludes that compassion compels the church in Africa to act in the face of HIV and AIDS because “Business as usual” becomes impossible when the churches are moved with compassion to translate compassion into concrete action that seeks to mitigate and eventually remove the pain caused by HIV and AIDS in its ministry (2016).

The fifth reason cited by Parry is the church’s theological mandate to fulfil the teachings of Jesus as in Matthew 25:31-46 (2013:7). Jesus demonstrated compassion not by promising the persons that live on the margins of the society that their reward would be in heaven, but by acting decisively to restore the full human dignity in this life (Chitando 2007:54). In the sixth point, Parry states that the church is not an island but a community within a community and that the HIV and AIDS era has been and remains a Kairos moment for the church to bring transforming love, health, healing and restoration of hope and dignity to everyone regardless of HIV status, colour, culture, creed, ethnicity or sexual orientation (2015:7). Moyo “holds that what affects the community invariably affects the church. The church takes part in the fight against HIV and AIDS because it has disturbed our comfort zone and our conventional theologies have been challenged, making us face inadequacies and our prejudices in the light of the Lord’s transforming love” (2015:7). Parry concludes that every human life is created in the image of God and is sacred and worthy of that promise of abundance (2013:101; see also Mujinga and Moyo 2016). Healing ministry is therefore an act of restoring lost human dignity. The disengagement of MCZ from HIV and AIDS ministry automatically disqualified the church as a sanctuary for healing ministry because for healing to happen, people need a place where they can be comforted in sharing their pain (Mujinga and Moyo 2016:57).

Happonen, Jarvinen and Virtanen (n.d:5) conclude that an HIV competent church understands healing ministry holistically. They further comment that in many African communities, people do not have access to a counsellor, psychologist, family planning counsellor or a medical professional; in such circumstances, they turn to the church for healing. The church should therefore be open to the needs of its member's because failure to do so means that its definition as a body of Christ will be compromised (Happonen, Jarvinen and Virtanen n.d:5; WCC 2005:77; Mujinga and Moyo 2016). "The church needs to create a safe space for people to experience healing within our church communities and therefore a practical step through which congregations can become healing communities" (WCC 2005:79). There is no way a church can be a healing community when it is quiet about HIV and AIDS.

5.9 Conclusion

This chapter examined the healing ministry in the independent Methodist Church. It analysed the 1977 Methodist Church in Britain's statement on healing ministry to identify what, if any, of its healing understanding and practice were bequeathed into the life and work of MCZ. In addition, the section also explored the healing ministry approaches of MCZ as stated in MacNutt's book on healing. The study examined how the ministry and mission of MCZ became a seedbed for the emergence of healing missions that broke away to become AICs in the post-independent Zimbabwe. Critique was made of Harvest Apostolic Ministry founded by Claudius Matsikiti and Revival Fires Apostolic Church established by Eden Chombo. The chapter ends by questioning the relevance of the MCZ in its healing ministry in response to the HIV and AIDS epidemic. The chapter concludes that when any nation practices poor governance, the majority will suffer. HIV did not come as an accident, but poor governance made it to be a designed epidemic that haunted the church for a long time. The next chapter focuses on factors influencing healing ministry in the contemporary MCZ namely, AICs and the newer Pentecostalism.

CHAPTER SIX

CONTEMPORARY CHALLENGES SHAPING THE HEALING MINISTRY IN THE MCZ SINCE 2008

6.1 Introduction

The previous chapter examined the healing ministry in the independent Methodist Church. It also analysed the 1977 Methodist Church in Britain statement on healing ministry to identify what, if any, of its healing understanding and practice were bequeathed into the life and work of MCZ. In addition, the section also explored the healing ministry approaches of Methodist Church in Zimbabwe (MCZ) as stated in MacNutt's book on healing. The study examined how the ministry and mission of MCZ became a seedbed for the emergence of healing missions that broke away to become AICs in the post-independent Zimbabwe. Critique was made on Harvest Apostolic Ministry founded by Claudius Matsikiti and Revival Fires Apostolic Church established by Eden Chombo. The chapter further questioned the relevance of the MCZ in its healing ministry in response to the HIV and AIDS epidemic. The chapter concludes that when any nation practices bad governance, the majority will suffer. HIV did come as an accident, but poor governance made it to be a designed epidemic that haunted the church for a long time. This chapter will focus on factors influencing healing ministry in the contemporary MCZ, namely, African Initiated Churches⁹⁶ and newer forms of Charismatic/ Pentecostal Churches.

Pentecostalism is divided into the old and the new movements, in which case the newer Pentecostal Churches or mega-churches in Zimbabwe will be the major focus of this research. The reason for assessing the influencing factors of AIC and Pentecostals was rightly stressed by Healey and Sybertz (1996:304) who acknowledge that healing was important in the early Christian church, yet ironically, the healing aspect of the ministry has been inculturated in only some Christian churches in Africa today, such as AICs and different Pentecostal churches. The Catholic Church⁹⁷ and many Protestant Churches such

⁹⁶ Debates around the proper name of AIC have been elaborated in the first chapter of this research.

⁹⁷ The point raised by Healey and Sybertz (1996) on Catholics being hesitant to initiate healing ministry is somehow misleading. There are some examples of Catholic individuals who are known for having taken a leading role in healing ministry, unless they are talking about Catholic Church as an institution. In the global world, one would think of Francis MacNutt. Although he is no longer a Catholic, he published and healed as a Catholic. In Africa, we have an example of Archbishop Emmanuel Milingo of Lusaka in Zambia who resigned because of the Vatican pressure (Ter Haar 1992:381). Writing from Nigerian context, Ugwu

as Anglicans, Lutherans, Methodists and Presbyterians continue to hesitate and hold back in this regard (:304).

The other reason for selecting African Initiated Churches⁹⁸ (AICs) and newer Pentecostal churches is the scholarly debate on the difference between AIC and Pentecostal churches. Scholars like Cox (1995:254), advocates that the two institutions represent two sides of the same coin. In his submissions, Cox holds that AICs are like Pentecostals because their background, origins and their style of worship portray similar tendencies. This point was supported by Chitando, Gunda and Kügler who argued that Pentecostals and AICs are splinter groups from the Protestant churches, based on some theological issues that include healing ministry (2014:57). It is however not within the scope of this missio-cultural research to take the debate further; suffice to state that the two will be regarded as two different but rich centres of theology that have an influence on the healing ministry of the contemporary MCZ in the MEM societies. The chapter will grapple with the coming together of mission and culture in the Zimbabwean milieu using inculturation lenses.

The MCZ stands in the apostolic tradition. This tradition is enshrined in the policy book of MCZ. “It cherishes its place in the Holy Catholic Church which is a Body of Christ. It rejoices in the inheritance of the apostolic faith and loyally accepts the fundamental principles of the historic creeds and the Protestant Reformation” (MCZ *Deed of Church Order and Standing Orders* 2007:2). This statement concurs that the healing ministry should be central to the ministry and mission of MCZ. Bate (1999: ii) states that healing ministry is central in the scriptures to people’s faith. Therefore healing can be argued to be a principal factor in attracting new converts who are in need of receiving healing (Porter & Avalos

(1998:17) notes that there are a number of prominent Catholic faith healers. Ejizu also acknowledges that these healings have created some challenges with the church leadership who argue that the ministry deviates from the teachings of the Church and some appear pagan in nature (1972:11). For Ejizu, this healing is problematic because the healers are considered psychologists and not spiritual healers. In the same manner, the Zimbabwean Catholic Church has Fr Urayayi of Super Roma in Masvingo. According to Shoko (2006:352), Fr Urayayi’s methods of healing embrace prayer, laying on of hands, and splashing water and salt. Most of the patients he ministers to suffer from various chronic illnesses and diseases and for one to be healed, they must believe wholeheartedly in God (:355). According to Wermter (1989:11), in the understanding of Roman Catholics, leaders are God’s instruments. The medical profession is doing God’s work and continuing Christ’s healing activity. Medical work is therefore close to the heart of the church which will always insist on being directly involved in caring for the sick.

⁹⁸ The different terms used to describe AIC have been discussed in chapter one.

2000:3). However, AIC and Newer/ Charismatic Pentecostal churches have become challenges in the contemporary MCZ.

6.2 The Influence of African Initiated Churches on the Healing Ministry in MCZ

African life is a vicious cycle of health and illness. The two paradoxes present life as a religious drama where healing and health forms part of African spirituality. For some time, AICs had been at the centre of addressing African spirituality as far as healing is concerned. One of the reasons for their healing theology was clearly espoused by Appiah-Kubi (1981) who stresses that AICs address the needs of the African souls, subsequently providing the members of the church with tools to fight the forces of the evil world as they endeavour to express themselves in African society, such as diseases. For Chitando, Gunda and Kügler (2014:7), healing is the recruitment technique of AICs (see also Machingura 2014). Methodist members sought healing anywhere where it could be found and AICs provide another source of hope for them. What probably makes healing in AICs appealing is the fact that it is an inculturated form of spiritual healing. This scenario, for Mukonyora (2007), is the other reason why some people leave traditional churches to join AICs – to find solace and answers to their ailments.

Healing is central to humanity regardless of the individual's religious affiliation. Lartey states that as human persons, we find ourselves broken and bruised by ailments. Healing therefore comes as an answer to something that we feel we had lost, and something we had been enjoying had been recovered (2003:62). Analysing this point theologically, healing is one of the key reasons for humanity's belief in the deity. Against this backdrop, Togarasei (2009) holds that since AICs have a long history of healing, it is therefore central in their ministry and they attract converts because of this unique niche that differs from the mainline churches (see also Gunda 2011; Biri and Togarasei 2013). Given the fact that the missio-cultural research has made it clear that MCZ is a mainline church, Togarasei's assertion would be right that some MCZ members have dual membership or have totally transferred to AICs. A few examples of some healing emphasis in Zimbabwe will help enrich this research. According to Chitando, Gunda and Kügler (2014:45), The Zion Christian Church of Mutendi specializes in exorcizing evil spirits and treating some ailments that are believed

to be incurable by using coffee, holy water, salt, tea or injection.⁹⁹ Mwazha emphasises faith healing, as argued earlier, in eradicating witchcraft, and he puts his healing testimonies in the national newspaper once every week (Chitando, Gunda and Kügler 2014:57). Johane Marange claims that he can heal any form of disease (Chitando, Gunda and Kügler 2014:57). Cox adds that healing in AICs goes beyond physical restoration, to providing solutions for unemployment, material discords, misfortunes and disputes. These forms appeal to the African society to visit AICs, and MCZ members in MEM are no exception (1995:54).

The growth of AICs, according to Pobee (2001), is related to the failure by many missionaries to address issues of healing ministry, as discussed in chapters 4 and 5. Missionaries did not only fail to address healing issues, but their medical centres failed as well, based on the same reasons (Gunda 2011:143). Although many African writers concur that healing is the heartbeat of the AIC, other writers (for example, Gundani 2007; Biri 2012; Chitando, Gunda and Kügler 2014; Shoko 2015) are convinced that the prophetic methods used in these churches are similar to those of the traditional healers because they specialize in exorcism and the attraction of pathologic objects from the clients. Since Africans believe in healing by seeing some tangible things being given to them or coming out of them, one is compelled to comment that as some church members in MEM societies strive for their spirituality, in the mission churches, AICs provide some solid and vivid solutions. The AICs claim to heal every ailment, HIV and AIDS included (Togarasei 2009).

Given the disengagement of MCZ from the healing ministry of HIV and AIDS, its members would find it easy to visit such healing institutions to receive a solution to their healthcare challenges. Whereas mainline churches have tended to invest in bio-medicine and have understood the importance of faith healing, AICs have put a lot of emphasis on faith healing (Pobee 2001). Unlike in the mainline churches, healing ministry in the AIC takes place in the context of cultural beliefs and the values of the people they serve (Echema 2006:32). It is inculturated healing that probably attracts some Methodist members in MEM societies. Togarasei adds that the community always endeavours to visit the *n'anga* or AIC prophet

⁹⁹ Chitando, Gunda and Kügler (2013:9) caution that the injection must not be taken to mean the one used by the medical people, but the church has its own needle and injection.

even if the ailment is proved scientific and biomedicine has been used (2009). Taking the point raised by Echema and Togarasei, further, it is uncommon to assume that people who are attracted by the AIC claim that the prophet reveals the individual challenges without being told by the concerned person. This scenario also justifies the reason why some MCZ clergy called themselves prophets, in order to be relevant as far as healing ministry is concerned.

The fact is that healing defines AIC services; it is probably the reason why most people from the mainline churches visit them. According to Amanze (1998:177), people reluctantly visit AICs because there is not much different between faith healing and traditional healing and the healers both concentrate on causes. This is unlike in the mainline churches, including MCZ, where healing ministry theology is not clear for some unspecified reasons. This is contrary to John Wesley, whose ministry was rooted in healing ministry theology. Given the missio-cultural challenges in MEM societies, it is not surprising that some members take either route to seek healing solutions. The preference of these healers is also justified by the fact that unlike in the MCZ where theology of healing ministry is obscure, AICs have a variety of healing methods. These methods range from prayer, administration of water mixed with ashes, animal sacrifices, induced vomiting, ritual bath, healing by steaming, wool string of different colours, exorcism, massaging, or healing using traditional medicine (Daneel 1970:67). Thus, the AIC has influenced the definition of healing ministry in the Methodist Church in Zimbabwe in recent years, especially as its approach is not different from ATR.

6.3 Newer Forms of Charismatic/Pentecostal Churches

Pentecostal churches are divided into the old and newer or charismatic churches (Anderson, 2000, 2002, 2007; Maxwell 2006; Ukah 2007; Adogame, Gerloff and Hock 2008; Asamoah-Gyadu 2010; Kaunda 2017). The former refers to those churches that sprouted from the mainline churches in order to give expression of their unique existence (Adogame, Gerloff and Hock 2008:192). In Zimbabwe these churches arose before the independence of the country. According to Chitando, Gunda and Kügler, “Apostolic Faith Mission and Zimbabwe Assemblies of God Africa (Forward in Faith) (ZAOGA) (FIF) are some of the largest Pentecostal denominations in Zimbabwe and can be traced to the early decades of the twentieth century” (2014:15).

The latter are those movements that arose out of the socioeconomic crisis of Zimbabwe from the year 2008. While some of these churches like United Family International Church (UFIC) led by Emmanuel Makandiwa and Heartfelt led by Tavonga Vutabwashe are offshoots from the Apostolic Faith Mission (AFM), other movements like Prophetic Healing and Deliverance Ministry (PHD) led by Walter Magaya and Spirit Embassy founded by Urbert Angel arose out of the Zimbabwean socioeconomic crisis. According to Kalu (2008), the founders of Pentecostalism, from 1900 to 1960, tilled the soil on which modern Protestantism thrives. Togarasei confirms this point by stressing that in the past twenty or thirty years in the history of Zimbabwe, Christianity has witnessed the emergence of the new breed of Pentecostalism that tends to attract the middle and the upper class urban residents. This Pentecostal movement also pulls the elite (2005:355). Having been formed by reasonably well educated urban youth, Togarasei contents that the church remains an elitist and modernist movement although it is true that not everyone in the church is rich or educated. The church appeals to those who are seeking both success and prosperity in life (2005:355). The tenets of the newer charismatic movements make them appealing to the healing needs of the people. It is somehow wise not to deny that these characteristics of charismatic churches are the ones some MCZ members in MEM societies are longing for since these churches are inculturating healing ministry.

Newer Pentecostal Churches in Harare being studied include: United Family International Church (therein UFIC) founded by Emmanuel and Ruth Makandiwa; Spirit Embassy started by Urbert and Beverly Angel; Grace Unlimited instituted by Prophet Kanyati; Heartfelt Ministries headed by Tavonga and Chipso Vutabwashe; Oliver and the late prophetess Makanyara Chipunza; Yasmin of Kingdom Embassy and steered by Passion Java; and Revival Centre World Ministry run by Adventure Mutepefa (Vengeyi 2013:29). On the list also is Prophetic Healing and Deliverance Ministries (PHD) founded by Walter Magaya.¹⁰⁰ One notices the theological challenges to healing ministry that MCZ is struggling with given that the societies under study are in Harare where these churches are also found.

¹⁰⁰ Prophetic Healing and Deliverance Ministries, led by Walter Magaya, is the youngest in this prophetic ministry in Harare. Of late, both Zimbabwean print and electronic media is awash with the name of Walter Magaya together with other names like Makandiwa and Angel (Mujinga 2017).

Among these Newer Pentecostal Churches, three that appear at the top of those influencing healing ministry in the MCZ are UFIC, PHD and Heartfelt. The Zimbabwean print and electronic media is awash with these newer Pentecostal churches (Biri 2012; Masvotore 2016; Chitando, Gunda and Kügler 2013; Vengeyi 2013; Shoko and Chiwara 2013; Biri and Togarasei 2013; Mapuranga 2013; Mwandayi 2011; Chitando, Manyonganise and Mlambo 2013; Shoko 2015). The impact of these prophets is more felt than explained by the mainline churches. A case in point is Walter Magaya who is claimed by some social commentators to be one of the most influential figures under the age of forty and also ranked the third most influential person in Zimbabwe with PHD ministries having been ranked as one of the fastest growing churches in the country (eNCA: 11 April 2015). Moreover, Magaya is also presented as one of Zimbabwe's most sought after "super high preachers" in Zimbabwe. Vengeyi (2013:29) confirms that Makandiwa, Vutabwashe and Angel attract more than forty-five thousand followers every Sunday, which has never happened in Zimbabwe. However, Kamhungira and Chaya (2014) stress that by 2014, Magaya had eighty thousand followers every Sunday, which makes him a prophet of the moment. Some of the former Methodist members who were interviewed are now members of these churches.

Pentecostalism and its charismatic variations have become the representative face of Christianity as it grows fast across continents, including Africa South of the Sahara. However, within the last decades they have been overtaken by neo-Pentecostal churches, which are more charismatic in nature. The rise of Pentecostal/charismatic movements in African countries has inspired new ways of dealing with life's challenges (Asamoah-Gyadu 2010:56). A critical area for the movement is the healing and deliverance ministry through which supernatural evil is confronted so that church members would get spiritual freedom. According to a few programmes gathered from MCZ events and MEM societies (See appendices 12-14), it is evident that the programme of healing and deliverance has become central in the MCZ, leading one to suggest that MCZ's newer charismatic churches have shaped the ethos, mission and theology of the MCZ (see Easter programmes for MEM societies, MCZ Ministers Retreat Programme and Minutes of Conference of 2014).

There are a number of factors that justify neo-Pentecostalism's influence on the healing ministry in the MCZ. First, according to Anderson (2007: 37), divine healing was rarely part of the Protestant missionary establishment's practice as a whole and it was only with the advent of Pentecostals in the Twentieth century that this practice became more

widespread. Pentecostals have seen healing as good news for the poor and afflicted (Anderson 2007:37; see also Anderson 2002:523). In driving the point home, Anderson confirms that because of the possibility and proclamation of healing and miracles in Pentecostalism, people could relate to it in their own context and see it as a “powerful” religion to meet their needs (:341). Given the unspecified stance on healing ministry theology by MCZ, and the general poverty in Zimbabwe, it is not surprising that some church members in MEM societies visit these churches in search of healing ministry. The Bishop of the Methodist Church (now Presiding Bishop) Rev Farai Chirisa’s address to 1991 Conference where he laments that worship in the MCZ remain westernized and it leaves many hearts untouched (1991), is a clear indication of the dilemma the MCZ has with healing ministry. Western forms of worship in the MCZ remains one of the reasons why dual membership is rampant, because the worship is very formal and does not leave room for flexibility. By the year 2000, there were no deliberate efforts undertaken by the MCZ to localize Methodist forms of worship. MCZ worship services have more foreign concepts and components than local (2000:18). Chirisa bemoans worship that is divorced from the culture of its people. This type of worship is a recipe to fall short of meeting Methodist members’ ecclesiastical needs. This gap is seen where some MCZ members visit newer Pentecostal churches for healing or prophecy in times of crisis but return to MCZ because the pastoral care of Methodism is beyond comparison (Madhiba 2000:18).

Second, the thirst for healing among MCZ members in MEM societies is not quenched in their traditional church, as evidenced in this discussion. As such, some move out to Pentecostal churches. Mangena and Mandizha hold that during the church services, Pentecostal prophets employ “tailor-made sermons” to appeal to psychological, material, physical and spiritual breakthroughs on issues of health and wellbeing, business, employment opportunities, wealth creation and general prosperity (2013:138). It is exceptional that given the economic meltdown in Zimbabwe, Methodist members from MEM societies find these churches as havens of their health challenges. This type of gospel, according to Jones, has a number of names, starting with prosperity gospel, ‘name it and claim it’ gospel; ‘blab it and grab it’ gospel; ‘health and wealth’ gospel; word of faith movement; the gospel of success; and the positive confession theology (2014). Jones adds that the movement’s many names means it is the in-thing; it is also called the teaching that God want believers to be materially wealthy (2014:79; Ukah 2007:1-20; Kalu 2008; Togarasei 2011; Masvotore 2016).

Third, the factor that attracts MCZ members in MEM societies to newer Pentecostal churches is the definition of healing ministry theology that includes aspect of prophecy, exorcism, speaking in tongues, spontaneous prayers, exuberant liturgical expression and the emphasis on dreams and visions. These have an impact on MCZ (Ukah 2007:1-20). Some of these factors are common among African traditional healers and AICs. However, newer Pentecostal churches do it with charisma and people feel good to be identified with them. Magaya has even gone to the extent of naming his movement Prophetic Healing and Deliverance Ministry, claiming that it is one hundred percent prophetic, one hundred percent healing, and one hundred percent deliverance (PHD website). In a country that is economically depleted and religiously contested, these newer Pentecostal churches draw masses from the mainline churches. The prophets also come as competitors; as such, they release new tricks every day to attract followers, and MCZ is not an exception.

Fourth, “newer Pentecostal Churches attract Africa’s upwardly mobile youth, they have a penchant of mega-sized urban centred congregations, regard themselves as international, use of English as the medium of expression, a relaxed and fashioned conscious dress code for members, innovative appropriation of modern media technologies, a well-educated leader, not necessarily in theology and a very modern outlook is what makes them unique” (Asamoah-Gyadu 2010; Taru and Settler 2016). Given the challenge of unemployment in Zimbabwe, most of the categories of these people advocate for tangible things. As such they transfer their faith to these churches.

Fifth, apart from the need for healing, the church members from the mainline churches are attracted by these churches’ religious advertisement. Ukah maintains that these churches use posters, branded vests, caps, open television channels, and also make use of both electronic and print media. Whenever they have any function, big posters are seen all over the public places (2007). The national broadcaster will also suspend other programmes to attend to Magaya or Makandiwa programmes (self-observation). The advertisements publicize the promises for signs, wonders, miracles, healing and prayer for the diseased (Mangena and Mandizha 2013:138). Such actions by neo-Pentecostal churches make their gospel appealing, thereby accepted by most people since it is believed to be a tool to rehumanize the dehumanized populace. A case in point is the claim by Prophet Makandiwa

that he can bless his followers materially. These blessings include “miracle money”.¹⁰¹ Among the controversial miracles the prophet was alleged to have performed was “raising the dead”, enabling barren women to conceive and deliver in three days, and prophecy of gold and diamonds appearing in congregants pockets and hand bags (Zimbabwe Broadcasting Corporation (ZBC); News 5 February 2013).

Sixth, the way mega-churches attract people is succinctly juxtaposed by Biri and Togarasei. The two scholars cite Makandiwa and Angel telling people their physical address, names of their relatives, the type of music they like, and their national identity numbers (2013:82). If one subscribes to these claims, it is tempting to assume that religion is being used as a drug to make the believers get drunk so that the preacher draws resources from the “spiritually drunkards” who, when sober, realize they are bankrupt but cannot leave because there will be some more tricks introduced by the prophet to lure them further. For example, Magaya controversially instructed his followers to write their problems down, and he took them to Israel to hand them over to God at the gate of heaven in Israel (Zimnews 2017; see also Nyamayaro 2017). In spite of these seeming challenges of spirituality in new Pentecostal churches, Chimuka argues that the mega-churches in Africa in general and Zimbabwe in particular specialize in miracle campaigns. These miracles are characterized by healing programmes, evening deliverance and prophecy. During these deliverance sessions which appear as the primary function of Pentecostal churches, the prophet encourages his members to make a complete break from the past (2013:145).

Exorcism in the newer-Pentecostal churches includes the removal of such spirits like *ngozi* (the avenging spirits), *chikwambo* (gobbling), and other misfortunes that cause barrenness (Maxwell 2006:207). People are also attracted by the pronouncements of success in public by the prophet, promises of marriages, and the ending of challenges in life. The prophet’s healing method will be displayed on the screens such that even people who are far away will still witness it as the congregants will be testifying. Taringa maintains that since Africans believe that diseases are caused, the prophet will take the ATR approach which the patient holds (2013:208).

¹⁰¹ In 2013, Prophet Makandiwa was on record claiming that he can miraculously deposit money into the accounts of his members. What appeared strange was that the money could not be accounted through the normal financial procedure (see also News Day January 13, 2013, January 08, 2013, January 30, 2013, Daily News, February, 06, 2013, Herald January, 05, 2013 and the Standard January 06, 2013).

Chimuka notes that “other luring methods of newer Pentecostal churches include slogans covering the walls of Africa’s large cities that bear witness to the growing visibility of Pentecostal movements in Sub-Sahara Africa” (2013:113). Chimuka feels that neo-Pentecostal churches and AICs are two sides of the same coin in their emphasis on healing versus the stammering voices of the mainline churches on the same subject. The two streams of Christianity are meant to cover the void left by mainline churches which placed emphasis on physical healing at the expense of the spiritual aspect (2013:113). Since healing is a controversial subject in the MCZ in general and MEM societies in particular, it is not surprising that members flock to the neo-Pentecostal churches and AICs where healing ministry is at the centre of every service. In buttressing this point, Chimuka maintains that life in Pentecostal churches revolves around healing. The prophet promises people that all their suffering would end, as long as they heed God’s voice and contribute to the church; in the case of Pentecostal churches, tithes and pledges (Biri and Togarasei 2013:82).

Suffering in Africa is generally classified among misfortunes (Shoko 2007:59). In order to deal with misfortunes, church members go to the neo-Pentecostal churches and AICs as desperate church members seeking healing. Misfortunes are classified under spiritual problems that need spiritual help. For Machingura, “the emphasis by neo Pentecostal churches on spiritual protection, deliverance and healing makes a lot of sense to an African audience as it addresses economic, social and spiritual problems” (2011:73). Machingura contends that “it sounds theologically correct and is a relevantly familiar to Africans as they are particularly accustomed to the world of unseen spirits some which are good or bad” (2011:73). Machingura concludes that healing is an omen not only limited to physical sickness but it encompasses all aspects of anguish, which are detrimental to both the psychological and spiritual life of the sick person (2011:73). This point answers the probable reason why Methodist members have a dual membership, especially that the country has limited medical centres with few resources. Faith has taken over the place of scientific medicine.

Seventh, Asamoah-Gyadu shares that, “healing in Pentecostal churches tends to be the major factor that draws people into it. This is more in Africa because health and wholeness are generally sought within religious context. Religion is expected to deal with the effects of evil caused by demonic spirits and witchcraft” (2010:64; see also Asamoah-Gyadu 2004:389). Asamoah-Gyadu states that “in Pentecostal churches, healing ministry deals

with the effects of suffering, whether caused naturally or supernaturally can be dealt with through the power of the Holy Spirit often working through the anointed people of God” (2004:390). The fact that healing ministry in the MCZ is treated as an event means that church members in MEM societies find it easy to locate their faith to these new movements where healing is more often inculturated and forms part of every service. Newer Pentecostal churches, just like the AICs, also address the issue of witchcraft, sickness, failures, childlessness and other setbacks (Asamoah-Gyadu 2010:65). “These aspects of African spirituality make these churches attractive to the MCZ members. Anderson confirms this assertion as he points out that the newer form of Christianity is fast becoming one of the most significant expressions of Christianity in African continent especially in African cities” (2000: 260). In view of Anderson’s assertion, Asamoah-Gyadu might therefore be right to argue that “together these new streams of Christianity are reshaping Christian ministry, mission, spirituality, worship and theology in most parts of Africa” (Asamoah-Gyadu 2010:65).

Eighth, church members in the newer Pentecostal churches in Zimbabwe have partnerships with their prophets. Magaya and Makandiwa attach the spirituality of their members with partnerships that are paid for. The fact that the two are believed to be true messengers of God means people stampede to want to see, touch and talk to them personally. As such, there is a competition to pay more to have more time with the ‘Man of God’. According to Masvotore, Makandiwa has partners which resemble a spiritual covenant (2016:25). Masvotore further argues that spiritual covenant means one is partaking of the calling and commissioning of the ‘Man of God’ - Prophet Makandiwa - by God to Zimbabwe, Africa and the rest of the world. Prophet Makandiwa loves and cherishes one’s commitment, and one’s partnership with him will not go without reward. There are many benefits one will enjoy as a partner, which includes special conferences with Makandiwa and an opportunity to be with him personally. In this partnership, individual families and various entities count themselves as supporters of the ministry financially or materially on a regular basis. This is done through making regular transfers or donations to the ministry” (2016:25).

In the same concept of partnership, Magaya also has these circles. What makes the partnerships to have impact in the healing ministry is that health and wellbeing are given one-on-one attention by the prophet. Observably, most of the families in MEM societies are torn between mainline and Pentecostal faith. This kind of relationship with the prophet is so

publicized that MCZ members in MEM feel happy to be partners of these prophets although this is not publicly declared (Chakanya 2016).

Ninth, prophecy is priority number one in the newer Pentecostal churches. A case in point is Magaya's predictions of 2016 as a year of abundance and great economic fortunes for the country (Nehanda Radio 4 Jan 2016). In the same way, his counterpart Emmanuel Makandiwa also predicted a better life for Zimbabweans in the same year (Nehanda Radio 4 Jan 2016). According to Shoko, "Prophet Makandiwa had previously declared 2012 as a 'Year of Results' and some members of his church were already enjoying the declared results of 2012 as shown by posters and stickers which are seen on many vehicles in town and other properties which reads, 'This is a result'" (Shoko 2015:33). Magaya made the same claim in his Waterfalls shrine. Before making the announcement, Magaya told his followers that he had travelled to Nigeria to confirm with his spiritual father, Temitope Balogun Joshua, on the economy of Africa and whether what he was seeing was true. Magaya claims that "ask your neighbour how big his/her house is, the wardrobe and the garage... this is a year of overflowing" (Nehanda Radio 4 January 2016). Maxwell confirms the background of such claims when he points out that in newer Pentecostal churches, people are taught to expect and seek change and to expect an experience of the sacred. During the services, people are repeatedly told, 'you will never be the same again, or you will go home transformed'. Such theologization of hope can be argued to be one of the reasons why MCZ members are attracted by the newer Pentecostal churches of "claim it" "receive it" (2006:209; Jones 2014).

Tenth, Ukah (2007:10) argues that "the newer Pentecostal churches produce huge array of videos, magazines, CDs, DVDs, books, key holders and other religious memorabilia or ritual paraphernalia like handkerchiefs and olive oil". "Some of the artefacts are worn making them attractive to others as agents of protection. The newer Pentecostal churches also use therapeutic substances including the blessed water and anointing oil" (Ukah 2007:12). Although the use of water and oil is not unique to them, they are also common among the AICs and traditional healers. These healing substances have become common among the Methodist ministers as a way of attracting the people back from these churches. Anointing oil is common in PHD ministries and according to the PHD ministries website, it is a symbol of God's healing and deliverance power (PHD Website).

For Magaya, “anointing oil is also a point of contact in spiritual warfare and is a symbol of the Holy Spirit” (PHD Website). “The oil protects the followers from the deadly dangers and traps. It does the cleansing and purification” (PHD Website). Magaya claims that “anointing oil in PHD destroys or breaks the bondage, burden and oppression caused by the devil because the enemy’s yoke connects and binds people with sin, poverty, diseases and limitations, it also breaks the yoke that is used to seal the promise of God made to his children” (PHD Website). One of the PHD members confirms that anointing oil is one of the major mantles of the ministry that has brought thousands to testimonies. “The oil applied to all the affected parts of the body e.g. the forehead, head, eyes etc. One can also apply it to the affected parts of life like documents or business ware” (PHD Website). In demonstrating the importance of such artefacts to his followers, when Magaya visited South Africa in Durban, a number of ‘anointed’ artefacts were being sold. An “anointed pen” was costing ZAR 10, “anointed red candle” ZAR 30, “wristbands ZAR 50, T-shirts ZAR 150, and DVD with Magaya’s sermons ZAR 100” (Mtshede 2016). Mtshede cites one South African who is responsible for the PHD ministries office in Durban, claiming that: “My sister, these candles are important because the prophet prayed for them and one can use them every night to pray and ask anything as you connect with various people who purchase these candles as well” (Mtshede 2016).

Magaya confirms that the box and the container of the so-called “anointing oil” is part of the mantles that he uses in reference to the mantles of the biblical Moses and Elijah (PHD Website). He adds that, “the mantles have been prayed for so that the oil will have power for healing, deliverance, breakthrough, coverage from evil forces, spiritual warfare, opening closed avenues, exposing the devil, breaking the chains of bondage, maintenance of deliverance and spiritual nourishment” (Tafirenyika 2014). “The ‘anointing oils’ cost USD \$10 while jackets costs USD\$25.” Makandiwa also uses anointing oil with the same explanation of Magaya. Makandiwa claims that “anointing oil” brings glory. It deals with economic problems bedevilling the society as well as renders all other oils given elsewhere useless (Tafirenyika 2014). He is also cited as claiming that, “this one will cause noise and you (the members) will be the first ones to enjoy the fruits of the glory that comes together with the anointing oil. Nobody will overrun you and by the time they arrive (for the economic benefit), you will be enjoying the fruits already. Unlike the other counterfeit, this one has the presence of God” (Tafirenyika 2014).

According to Rupapa and Shumba, Makandiwa also cites biblical verses in support of his “anointing oils” (2014). He further claimed that his “anointing oil” can treat HIV and AIDS and cancer; as such, no church member should be allowed to come and grab it (2014). From the claims of the two “prophets”, one notes that the way they advertise their anointing oil leaves the non-members with an impetus to want to have the oils, thereby practicing dual membership or complete transfer of their faith to these newer churches. Although Shoko confirms that Makandiwa uses a variety of methods and elements to heal, the methods are similar to the traditional healers (2015:31). The same conclusions are true with Magaya, and the researcher concedes to this philosophy. In support of this point, the researcher feels that this form of advertising has a big influence on the theology of healing ministry in the MCZ in the context of the socioeconomic meltdown of Zimbabwe. The use of anointing oil and other religious artefacts has become viral in MCZ with some ministers actually using them as a way to retain membership (Chidzambwa 2016; Ndhumbi 2014).

6.4 Conclusion

In concluding this chapter, the research has demonstrated that MCZ’s MEM societies in Harare are torn in their religious life. The fact that most people in Harare are influenced by the Shona ethnic worldview has caused ATR to have an impact on the healing theology of MCZ. The AIC has also proved to have an influence on the way the MCZ appeals to their healing ministry theology because all the programmes for major events like all-nights, revivals and Easter always have a programme on healing and deliverance. Lastly, the newer Pentecostal churches have proved to be one of the serious challenges to healing ministry in the MCZ. The conclusions of this chapter will lead the study to the research design, methodology and methods where the methods of data collection will be analysed.

CHAPTER SEVEN

RESEARCH DESIGN-METHODOLOGY AND METHODS

7.1 Introduction

The purpose of this chapter is to discuss and justify the research design, methodology and the methods that were used to collect data for this missio-cultural study on the healing ministry within MEM societies of the MCZ. The justification for this approach is the fact that any research conducted follows a research design that makes it unique from any other similar study. According to Kothari, research design suggests a systematic process that is used for collecting data, sampling and analysing that data (2004:8). Christensen adds to the same point by maintaining that research design refers to the outline of plan or strategy, specifying the procedure to be followed in seeking an answer to the research question (2007:39). In describing the research question, Trochim (2006) argues that it is like the recipe that provides a list of ingredients and the instructions for preparing the dish, and therefore, the research design provides the components and a plan for successfully carrying out the study. The research question undergirding this missio-cultural study is: “in what ways does MCZ participate in God’s mission within the context of diverse cultural understanding of healing in MEM societies? “Using this research question, the research design demonstrates first how the data for this missio-cultural study on the healing ministry within MEM societies of the MCZ was gathered and, second, the research instruments that were employed and how these tools were used to interpret the data (Kothari 2004:9).

Commenting on research methodology, Rajaseker, Philominathan and Chinnathambi hold that a methodology is a science of studying how research is done scientifically (2013:5; Kothari 2004:8). Research methodologies are divided into qualitative and quantitative (Kothari 2004:3). The case of this missio-cultural examination of the healing ministry within MEM societies employed qualitative research methods to study how MCZ members in MEM societies respond meaningfully to their healing needs. Qualitative research was chosen in line with the research question of this study. In view of this, Patton and Cochran admit that qualitative research aims to understand the experiences and attitudes of people (2002:3). The two scholars further argue that the method aims to answer the what, how and why of the phenomenon rather than the how many or how much, which are answered by the quantitative methods (2002:3). Given that healing ministry is a phenomenon, it therefore

justifies the use of phenomenological methods to investigate how the MCZ members in MEM societies are responding meaningfully to their healing needs.

In this phenomenological study, both church leaders and ordinary church members, numbering ninety-eight persons, were interviewed using in-depth and focus group interviews. The number ninety-eight came as a result of random and snowball sampling used in this research (See tables 1, 2, 3 and 5). These people include three clergy persons, church leaders, and ordinary members of the MCZ such as the elders and the youth and former Methodists. Zohrabi confirms that while quantitative research uses closed-ended questionnaires in order to collect, scrutinize and interpret data, qualitative research methods make use of interviews, diaries, journals, classroom observations and open-ended questions (2013:254). Qualitative research also aims to produce rounded understandings based on rich, contextual and detailed data (Mason 2006:4). The chapter will follow the following procedure: discussion on the phenomenological method that was used to interpret the understanding of healing ministry in MEM societies of the MCZ; research participants and sampling; data production, process and methods; data analysis process and methods; methodological limitations; and ethical considerations.

7.2 Phenomenological Method

“Phenomenology is a way of describing something that exists as part of the world humanity lives” (Hancock 2002:4). The phenomenological method therefore “aims at retaining the lived experiences of the people” (Groenewald 2004:2). It endeavours to ask the questions like, what is the meaning, structure and essence of the lived experiences of this phenomenon by an individual or individuals (Patton and Cochrane 2002:11). The points raised by Groenewald and Patton and Cochran justify the rational of using phenomenological methodology because the researcher had an opportunity to reach the ecclesiastical healing ministry experiences of the MCZ members in MEM societies of the MCZ. This point was succinctly expressed by Donalek who maintains that the “phenomenological method aims to describe the meaning that experiences held for each subject and is used to study areas where there is little knowledge” (2004:516-517). The literature review of the MCZ (Banana 1991; Zvobgo 1991; Madhiba 2010; Gondongwe 2011; Mawire 2015) has demonstrated that the subject of healing ministry has not received priority attention in the MCZ; hence this research becomes a key tool to further the knowledge in the academic field. In the preceding chapters, the research has found out that healing ministry in the MCZ is an urgent

topic and both the congregants and the clergy have mixed feelings on the subject (see MCZ Minutes of Conference 2011:13 and 2014:12). It was also evident in the chapters that the phenomenon has led to migration of some members from the MCZ, who have transferred their faiths to either Pentecostal churches or AICs (MCZ Minutes of Conference 2011:24).

In phenomenological study, “the researcher must first identify what he/she expects to discover and deliberately put aside his/her ideas” (Donalek 2004:517). The process of suspending preconceived knowledge about the subject as the researcher get into the field is called “bracketing” (Lester 1999:1). Bracketing is suspending judgements on everything which the believer uses to express faith and everything which he/she thinks manifests that faith, events or signs which the adherent affirm as making the object of faith (Cox 2000:31). Having bracketed the pre-knowledge about healing ministry in MCZ, the phenomenological method allowed the researcher to participate not as a Methodist member or minister, but more as an outsider soliciting information from the insiders. The advantage of this approach has been highlighted by Mapuranga (2010:18). She confirms that the phenomenological method produces unbiased research since the researcher will be using the lived experiences of the respondents and not imposing his or her knowledge upon them.

The phenomenological method was used in a number of ways in this missio-cultural study of the healing ministry with MEM societies of the MCZ. First, the researcher attended two Sunday worship services with each of the three societies. One of the services was conducted by the superintendent,¹⁰² who is regarded as the custodian of the MCZ in the respective society (MCZ *Deed of Church Order and Standing Orders* 2007 item 101:28). The other service on each society was being conducted by the Local Preachers.¹⁰³ The aim of attending the different services was to observe the response of the members to their healing needs during the worship services as they were being conducted by the minister, and the one conducted by the Local Preacher. Although Silverman (2006:30) discourages research by observing as an unreliable method of collecting data, citing that different observers may record the observations differently, Mouton (2009:111) feels that observation is one of the best ways of doing research. Contrary to Silverman, Mouton maintains that in observation, suspension of prejudice and biases is the prerequisite (2009:111). Mouton further cautions

¹⁰² "A Superintendent in the MCZ refers to a minister whose name stands first in the list of ministers appointed to Circuit by Conference (MCZ 2007:28) and is the custodian of the Methodist policies.

¹⁰³ (See footnote 62).

that systematic and accurate recording of the observations, establishment of trust and rapport with the interviewees in case of interviews, and creating optional conditions makes the research very effective (Mouton 2009:112). In view of Mouton's assertion, the interview of the church leadership and different groups in the MEM societies confirmed the observed results.

Second, the researcher attended one Easter programme of Mabelreign society (see appendix 13). On this Easter event, Mabelreign society was combined with six other societies in the circuit and some from Parktown Methodist Church (which is not being researched). In addition, the researcher also participated in the Easter programme of Epworth society. The society was combined with seven other Methodist societies in the circuit and two other circuits, Mabvuku and Goromonzi. This attendance enriched the study since the MCZ understanding of healing ministry proved to be the same. Moreover, the researcher was part of Mbare society's all-night revival and Easter crusade (see appendix 14). As one would notice in the appendices (12, 13 and 14), all the Easter and all-night programmes had sessions on healing and deliverance services. This point justifies the use of the phenomenological method in this study because it allowed the researcher to observe the healing ministry phenomenon and how the members view it. In reinforcing this argument, Yin avers that direct observation in a research field can focus on the human actions, physical environment or real world view. The opportunity of doing such observation is what makes phenomenological study a unique method (2014:11). For Patton and Cochran, observation closes the gap between what people say and what they actually do (2002:12). In this study of healing ministry, observation also helped to uncover some of the behaviours of some members which were not shared by the selected informants during the interview process or which they were not aware of. Bailey maintains that one of the chief advantages of observational study is that no structural set of categories is used. It allows the person being observed to structure the situation and allows the observer to learn to view the world of the one observed through his/her own eyes. Since the observations were conducted in the normal Sunday service, the setting was natural (1985:271).

Third, the researcher participated at an MCZ Minister's retreat where a paper on healing ministry was presented (MCZ Minutes of Conference 2014:12). The retreat was designed for all MCZ clergy, which includes the leadership of the church such as the Presiding Bishop, General Secretary, Mission Director, and Bishops of districts, Superintendents,

ministers and student ministers. The paper was presented by the former MCZ General Secretary who was also former District Bishop of Harare West District, Rev Dr. Simon Madhiba, Bishop of Hwange District Rev Tongayi Matamba and the Superintendent of Chibero circuit, one of the MCZ circuits with mission farms, Rev Johnson Makoti. The selection of these leaders who are not part of the societies under study demonstrated the need for academic research on the healing ministry phenomenon in the MCZ. Fourth, the researcher conducted in-depth and focus group interviews which will be discussed later in this chapter. The purpose of this phenomenological approach was to get the MEM societies to describe their healing ministry experiences and how they perceive them.

The phenomenological method employed in this missio-cultural study was carefully selected given that one of its aims is to provide a very rich and detailed description of the human experiences in the selected societies of the MCZ. Using the phenomenological method, the results of the study emerged from the data, instead of being imposed by a structured statistical analysis (Denzin and Lincoln 1998:14). Phenomenological method emphasizes the believer as the primary source of data (Cox 2000:150). The people who were interviewed were all adults who came from various classes of life, the old and the youth, the professional and the unprofessional, women and men, the educated and uneducated, married and single, and finally, those from different contexts like low density Mabelreign, high density Mbare, and peri-urban Epworth. In the phenomenological method, the believer is understood, respected and credited in order to refrain from imposing on them the interviewer's own values and judgments. In order to do this, the respondents were given consent forms to sign and were assured of the individual opinion's confidentiality. The justification of using phenomenological research as forwarded by Hancock (2002:4) "is that the methodology does not necessarily provide explanations but raises awareness and increases insights in the organization", and in this case, to the missio-cultural study of the healing ministry in selected MCZ societies.

Although the methodology appears lucrative, it has its own limitations. In explaining how phenomenological methods function, Cox cautions that the phenomenologist invariably neglect to explain how to practice "bracketing" (Cox 2000:31). Cox adds that "prescribing the suspension of bias is one thing, to achieve it is another. Until the actual meaning of

ridding oneself of all biases gets explained, the *epoche*¹⁰⁴ must remain only a forlorn idea, it will never be practical but only remain idealistic” (2000:31). Another shortcoming of the phenomenological method was cited by Mapuranga as she avers that “the respondents might withhold information that they may feel obscure, sensitive and confidential” (2010:18). This challenge was addressed first by the researcher’s personality as a minister of religion in the MCZ. This scenario gave confidence to the participants knowing that their contributions were confidential. Second, the researcher had smaller focus groups during interviews as required in the academic research interviews (Mouton 2009:155). These small numbers enabled all respondents to contribute something regarding the healing ministry. Third, the researcher grouped the participants heterogeneously and according to their social status. This approach was taken in order to classify the youth alone since they can discuss things more easily among their peers. The privileged were also classified alone, the same with the less privileged and the former Methodist members. By privileged, the researcher was referring to those members who are economically advantaged, the working class, and those with better wages, while the less privileged refers to those who are unemployed, pensioners or those who are lowly paid. This approach helped each group to feel free to express their experiences with the healing ministry at their society and in the MCZ at large. Fourth, during the interviews the researcher would probe some follow up questions for explanation and clarity from the interviewees.

Mapuranga notes that some participants may be reluctant to cooperate from the onset (2010:18). Five approaches were employed as a way of regulating this challenge. First, the participants were given consent forms. After reading, the researcher further explained the forms to make sure that every respondent was satisfied. Second, the researcher allowed the participants to speak in their own languages. Third, the researcher created a horseshoe formation in the focus group interviews so that everyone was feeling equal to the others. Fourth, the researcher visited the former Methodists at their homes because as former members, their home environment proved unthreatening to them. Fifth, both in-depth and focus group interviews were conducted at the church, which is a neutral venue. This allowed all group members to freely express themselves. These experiences highly enriched the study. These group dynamics also helped the researcher to unlock and tap the hidden

¹⁰⁴ In expounding the word ‘epoche’, Cox (2000:154) states that it is a process whereby the researcher/phenomenologist sees the phenomena from the perspective of the believer thereby deriving their theories from an empathetic interpretation of the phenomena of religious experience.

treasure of data from the participants by encouraging those who were reluctant to contribute their ecclesiastical experiences on the healing ministry at their society.

The other challenge faced by the researcher in using the phenomenological method of data collection was posed by the method itself, requiring the researcher to observe (Cox 2000:150). Although observations were done with the three societies both during the Easter period and some selected Sunday services, as argued earlier, the frequency was limited. Considering the geographical distance of the research area and the time frame of the study, the limitations were navigated by asking the same questions to all the groups interviewed in the category of in-depth and focus group interviews. This was also a way of emphasizing rigour and validity in the study.

7.3 Research Participants and Sampling

This section describes four categories of research participants, why they were selected, and how the sampling was done. In keeping with the key research question, the sample of the study comprised four categories of research participants, namely, MCZ leaders in MEM societies, the ordinary members of the selected societies, the youth, and the former Methodists members. “The selection of these participants was based on their ability to contribute to the understanding” (Feagin, Orum and Sjoberg 1991:6) of the phenomenon under study, namely, the missio-cultural examination of the healing ministry within MEM societies of the MCZ. The assumption was that the missio-cultural examination of the healing ministry as a phenomenon in the MCZ was subject to various interpretations by different groups in the MCZ’s theological discourse depending on their perspectives. Informed by this assumption, four categories of research participants were selected to illuminate how healing ministry was understood. The goal was to shed light on the different meanings the healing ministry had for the research participants, drawing on the notion that phenomenon carries different meanings for different people, from the point of conception to the point of practice and implementation (1991:6).

Prior to the actual fieldwork, a letter was sent to the MCZ requesting permission to conduct research in MEM societies. The letter explained the purpose of the study, and described the research participants to be involved from MEM societies and the methods of data production to be used. The letter also requested the use of the churches’ archives (see appendix 2) and permission was granted (see appendix 3). Similarly, letters were sent to the Bishops of

Harare West where Mabelreign and Mbare are located, and Harare East where Epworth society is. The letters were also sent to superintendents of MEM societies.¹⁰⁵ The letters requested the superintendents to help organize the groups and venues for both the in-depth and focus group interviews. In addition, the letters also informed the superintendents about the permission by the MCZ to conduct research on the missio-cultural understanding of healing ministry within their MEM societies. Lastly, since the superintendent is the resident minister of the selected society and also the one who has its pastoral oversight, it was therefore prudent to formally advise them of the study. The letter also advised the superintendent that he was selected to be the first interviewee and would be a link person between the researcher and the society (see appendix 5). The fieldwork was then conducted between June and August 2016 with the four categories of the selected research participants.

7.3.1 MCZ Leadership at MEM Societies

Under this category, the church leadership that was purposely selected is divided into two groups, namely, the clergy (superintendents) and lay leaders.

7.3.1.1 The Superintendents

The rationale for selecting superintendents for interviews was based on the fact that they are regarded as the custodians of MCZ doctrines and practices in the societies (MCZ Job Description of the Superintendents n.d:1). These officials were also included because of their responsibility in implementing the church policy, as stated in the MCZ Constitution, and also as the policies are formulated by the MCZ Conference (MCZ *Deed of Church Order and Standing Orders* 2007, Section 10 item 101:28). The superintendents are also the vanguards of the MCZ because of their strategic position as representatives and bureaucrats whose official duty is not only to guard the church policy, but also to ensure that policy change gets beyond bureaucracy into practice in their respective societies. This position of the three superintendents, namely, Rev Kudakwashe Paradza (Mabelreign Society), Rev Victor Chakanya (Epworth Society), and Rev Victor Chidzambwa (Mbare societies)

¹⁰⁵ Societies in the MCZ falls under a circuit. In the MCZ, a circuit refers several societies united for mutual encouragement. The circuit is led by the Superintendent and this minister works with other ministers (MCZ *Deed of Church Order and Standing Orders* 2007, Section 9, 37.1 and Section 10:101. P. 35 and 29).

qualified them to be the watchdogs of MCZ, thereby representing the voice of the church in their interpretation of the healing ministry phenomenon in MEM societies.

7.3.1.2 Lay Church Leaders

The second category of church leaders randomly selected were the lay leaders of the three societies. These leaders are the society stewards,¹⁰⁶ the leaders of the Ruwadzano/ Manyano (RM),¹⁰⁷ and Men's Christian Union (MCU)¹⁰⁸ leader(s). The society stewards were selected because they are responsible, together with minister (superintendent), for the pastoral oversight of the society and giving leadership. They also uphold and act upon the decisions and policies of the MCZ through the Leaders Meeting¹⁰⁹ (MCZ *Deed of Church and Standing Orders* 2007 item 621. p. 141). The assumption guiding the selection of these lay church leaders was based on the fact that they are MCZ policy implementers and also vanguards of the church in their respective societies and organizations. The stewards implement the policies in the whole church while the RM and MCU leaders implement the policies in the female and male organizations respectively (MCZ *Deed of Church Order and Standing Orders* 2007:347 and 348:72-73). In the event that any church member visits healing sessions outside the MCZ, the stewards can note this through reports from Pastoral and Fellowship Committees¹¹⁰ and then report to the superintendent through the Class Leaders¹¹¹ (MCZ *Deed of Church Order and Standing Orders* 2007 item 620:4 i-vii, p 141,

¹⁰⁶Society Steward is a full member of the MCZ who is appointed by the General Church Meeting Annual Meeting to lead the society in the ensuing year.

¹⁰⁷ Ruwadzano/ Manyano, is a fellowship of Christian women who are members of the MCZ (MCZ RM Administration and Policy 2014:6).

¹⁰⁸ Men's Christian Union is a fellowship of Christian men who are members of the MCZ (MCU Constitution 2013).

¹⁰⁹ The Leaders Meeting has authority and oversight over the whole ministry through reports presented by all committees at the church. The Leaders Meeting also manages the property of the church. It initiates actions and coordinate the work done in the church. The meeting is chaired by the Superintendent (Standing Orders Part 6. Section 60. Item 600. p. 137f).

¹¹⁰ Pastoral and Fellowship Committee is one of the committees that reports to the Leaders Meeting. Its responsibility is pastoral oversight to all members in the church, to see that the sick, bereaved and the poor are being taken care of. It also ensures that members who wish to move to other circuits or churches have properly transferred. It also considers any special issues regarding backsliders, disciplined or reinstated members. The committee is attended by the members from all church organizations (RM, MCU, Youth One Society Steward and the Minister in charge of the society). (MCZ 2009: Standing Orders 643. p .147).

¹¹¹ MCZ structure is organized into classes which in other churches are called cell groups or Bible study groups. Class meetings were started by John Wesley in 1742 (White 2000; Hogue n.d) with the aim encouraging, exalting, praying and doing Bible study together. Each class has twelve members under the leadership of a Class Leader whose duties include among others, exercising pastoral care over those committed to his /her charge, informing the minister of any special needs and handing over to the Society Steward/ Treasurer any church monies received from members (MCZ *Deed of Church and Standing Orders* 2007 items 620:4 i-vii, p 141, MCZ Class Book 2014:4).

MCZ Class Book 2014: 4). A total of 16 church leaders were interviewed as represented in table 1.

Society	Clergy/ Ministers	Stewards	Ruwadzano/Manyano	MCU
Mabelreign	1 rep	2 reps	2 reps	1 rep
Epworth	1 rep	1 rep	2 reps	1 rep
Mbare	1 rep	1 rep	2 reps	1 rep

Table 1: Showing Random Sampling for the MCZ Leadership at MEM Societies

7.3.2 Ordinary Members of the MCZ at MEM Societies

The ordinary members of the MCZ in this missio-cultural examination of the healing ministry within MEM represent three categories of people, namely, the full members,¹¹² the youth, and the former Methodists. The full members are divided into two classes, the privileged and the less privileged”. All the people who participated in these focus group interviews were selected using random sampling, which represents the whole, calculated from the sample (Mouton 2009:136). The sampling took into consideration the sex, age, education, geography, the privileged and the less privileged. These people had been selected because they represent the ordinary people in the church who often feel intimidated by the church policies and procedures. The advantage of grouping ordinary people in their social strata also helped the researcher to draw theology from below; this theology from the margins is important for this missio-cultural investigation of the healing ministry within MEM. Likewise, the different levels of education also helped the researcher to compare and contrast the ideas from different contexts of life as the participants were articulating their understanding of the healing ministry phenomenon. In all the three purposely selected focus groups, a total of eighty (80) ordinary members took part in the interviews.

¹¹² Membership in MCZ refers to all those who confess Jesus Christ as Lord and Saviour and accept the obligations to serve Him in the life of the church and the world. They are all are welcome as full members. These members should be baptised and confirmed as Full Members of the MCZ. These members have a privilege and duty to avail themselves at the Sacrament of the Lord’s Supper (MCZ *Deed of Church Order and Standing Orders* 2007:3 and 4 p 4-5).

	Youth			Privileged			Less Privileged		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Mabelreign	5	5	10	4	3	7	4	5	9
Epworth	4	4	8	3	9	9	5	5	10
Mbare	5	5	10	3	5	8	4	5	9

Table 2: Showing Random Sampling for the MCZ Ordinary members

7.3.2.1 Youth

The first category, consisting of twenty-eight (28) youth, both male and female, from the three societies, were interviewed through focus group interviews. Out of these 28 youths, 14 were male and 14 were female coming from the three societies (see table 2 and 3). The random sampling for the youth considered those with two years as full members of the MCZ who were also between the ages of 18-25. The justification for this criteria is that full members have the experience of the MCZ policies and procedures. There were two assumptions guiding the selection of youth between 18-25 years. First, they are young adults who can give their own consent to respond to questions, unlike those below the age of eighteen who need parental consent. Second, young people feel more at ease participating in a group than they do as individuals. As such, their coming together allowed them to speak with a collective voice (Patton and Cochran 2002:16).

Third, smaller groups are easy to manage, every member of the group has a chance to participate, and their coming together brings a wide range of ideas on open-ended topics (Patton and Cochran 2002:16). The other justification for identifying the youth is the fact that migration from the mainline churches is mostly affecting the youth, especially given the socioeconomic environment of Zimbabwe. Pentecostal churches have an entrepreneurial orientation that has resulted in increasing popularity among young people, university students and young professionals (Taru & Settler 2015:19; Diara & Onah 2014:398; Vengeyi 2011).

7.3.2.2 *The “Rich” members of MCZ in MEM*

The second category comprised the “rich” people, both male and female, totalling twenty-four participants from the three societies. The intention was to have ten people in each focus group; however there were between seven and nine people in each group because the group members were not easy to gather. These numbers were considered ideal since six to ten people are viewed as a reasonable number for a focus group (Ferm 2001:12). Over twelve people proves to be too big while with fewer than four, not enough total experiences exist among the members (Marczak and Sewell n.d). The focus group participants were characterized by homogeneity. In a homogeneous group, people freely discuss according to their occupation, history, social class, educational level, age, family characteristics, economic history gender and psychological aptitude (Narayan *et al* 2009:10). It is against this background that the participants for this missio-cultural study on the healing ministry within MEM were grouped into the two categories of the privileged and the less privileged. These categories, as argued by Narayan *et al* (2009:10) are identified in line with the ladder of life, where groups are formulated according to their social status.

Given this categorization, each group of these marginalized people had a voice to express their views on the healing ministry in the MCZ. The assumption undergirding this decision was that the worldview of the less privileged and the privileged “is not always the same (Narayan *et al* 2009:10). The less privileged in particular can express themselves among the people whom they feel belong to their social class. Taking this missio-cultural investigation of the healing ministry in the three societies as an example, one will not be surprised to learn that the responses were different, as will be argued in the next chapter of data analysis.

7.3.2.3 *The Less Privileged Members of MCZ in MEM*

The third category in this random sampling comprised the less privileged. A total of twenty-eight people took part in the interview process. Out of this number, thirteen were male and seventeen were female. The assumption guiding the division of full members into the privileged and the less privileged was that they represent the diversity of the societies under study. These are the privileged versus the less privileged and the educated versus the uneducated. The separation of the two groups was buttressed by Marczak and Sewell (n.d) who define a focus group as a group of interacting individuals having some interests or characteristics, who are given an opportunity to express how they think or feel about a

particular topic. In this missio-cultural study of the healing ministry within MEM, the less privileged were expected to give greater insights into why healing ministry has become a topical issue in the MCZ (Marczak and Sewell n.d). The coming together of these participants during focus group interviews generated rich diversity on the understanding of the healing ministry within MEM societies of the MCZ.

7.3.3 Former Methodist Members

The fourth category among the ordinary members interviewed were people who represented the former MCZ members from the MEM societies. The participants were selected using snowballing sampling. “Snowball sampling is used where potential participation are hard to locate” (Donalek 2004:24), and in this missio-cultural study, former Methodists were not only difficult to identify, but those identified were reluctant to participate in interviews. Those who participated were identified “using networks” (Kumar 2011:397). Both the church leaders and ordinary members of MCZ in MEM who participated in purposive sampling referred the researcher to the former Methodists they knew. The purpose of networking with the former Methodists was to elicit their experiences of healing ministry when they were still MCZ members.

Although the intended number was six to ten participants, as suggested by Ferm (2001:161), the minimum of four people per society became feasible. In total, snowball sampling was able to identify twelve former Methodist members, four from each society. Ferm goes on to argue that a group can have eight to twelve people depending on the researcher’s interest. However, if the researcher is interested in the unique expectations of specific segments, smaller groups of four to five homogeneous people make more sense (2001:161). Based on this scholarly argument, it justifies the reason why the numbers of snowball-sampled participants rested at four per society. One of the challenges that led to the small number of former Methodist participants was the subject of healing ministry itself, given that some of them moved out because MCZ was reluctant on this topic. As such, to have an MCZ member identify them was not easy. Another challenge is that some informants may refer the researcher to the people of their circle and as a result no new information will be obtained (Donalek 2004:25). In addition, it was not easy to identify more participants because some MCZ members were reluctant to reference those whom they know. Those few individuals who were identified referred the researcher to those close to them. The other challenge was

the representation of the group. It was not guaranteed because the researcher had no idea of a true distribution of the population of the sample (Donalek 2004:25).

Society	Male	Female	Total
Mabelreign	2	2	4
Epworth	2	2	4
Mbare	2	2	4

Table 3: Showing Snowball Sampling for Former Members at MEM Societies

7.4 Data Production: Process and Methods

Drawing on the notion of qualitative research, the study employed five methods of data generation, namely, in-depth, focus group interviews, open-ended interviews, observation and document analysis. According to Hancock (2002:9), data from qualitative studies is derived from face-to-face interviews, focus groups, open-ended interviews and observations. In this missio-cultural examination of the healing ministry, in-depth interviews were used with the church leaders, both clergy and lay leaders. Focus group interviews were employed with the ordinary members in MEM societies. Focus group interview questions were also designed for the former Methodists, however, only Mbare participants managed to be a focus group. Former MCZ members from Mabelreign were interviewed in three sessions. Two were interviewed as individuals and the other two were a couple. The same also happened at Epworth, where two were interviewed as individuals and the other as a couple. These participants were interviewed as individuals because grouping them was one of the major challenges.

7.4.1 In-depth Interviews

In-depth interviews were conducted first with the superintendents of MEM societies, and second, with three categories of church leadership of MEM societies to generate data. Christensen, Johnson and Turner argue that in-depth interviews allow the researcher to encounter people's life experiences (2011:308). In this missio-cultural investigation of the healing ministry within MEM societies of the MCZ, in-depth interviews allowed the interviewees to share their lived experiences of this phenomenon. The advantage of using in-depth interviews was rightly expressed by Silverman who argued that "in-depth interview

is ideal for measuring attitudes and most other contents of interest of the informants” (2006:117). During the interview process, both verbal and non-verbal communication of the group helped the researcher to calculate the validity of the contribution of the participants. In addition, the method also allowed the researcher to probe the informants for more data given that in-depth interviews allow the interviewer to follow up and to seek further clarity (Marczak and Sewell n.d). This probing opened the interviews and raised some deep-seated information that would not have been obtained by using structured interviews or questionnaires (Silverman 2006:117). Since the healing ministry is a topical phenomenon in MCZ, in-depth interviews helped with obtaining first-hand information from the participants, thereby producing raw data for the research (Burns and Grove 2005:118).

The interviews were also conducted at the agreed time with the participants. The arranged scheduled times were a priority for the informants. Some of the interviews for this missio-cultural examination of the healing ministry within MEM were conducted after the Sunday worship service, while others were held after the RM programmes on Thursday. Still other interviews were conducted after the participants had finished work. Others were held during a selected weekday during the evening in order to cater for those who go to work. Those interviews which were conducted after work were affected by time management because the researcher would go and wait for the respondents to come. Those interviews conducted during the weekdays were also a challenge because they were held during evenings since the participants indicated they did not have any other time. The chances of insecurity could not be overemphasized. Nevertheless, most of those who came at night had their own transport, which was an advantage for the researcher since they used their vehicles voluntarily. The other choice of using in-depth interviews in this missio-cultural study of the healing ministry within MEM was that the interviewer had the freedom to probe the interviewee to elaborate on the original response or to follow a line of inquiry introduced by the interviewer (Hancock 2002:10).

The in-depth interviews were effective during the missio-cultural examination of the healing with MEM because the method of data gathering allowed the researcher to make follow up questions to any point that might not be clear (Donalek (2004:517). In-depth interviews further allowed the respondents to describe their experiences as they provide them. The in-depth interviews employed in this missio-cultural study were divided into two sections (see appendixes 6 and 7). The first section explored the understanding of the healing ministry

phenomenon to the congregants of MEM societies. The questions included such inquiries like, the definition of healing ministry in the MCZ, and the extent to which it is a mission strategy of the church. The interview further inquired whether people seek healing ministry in the MCZ and investigate whether there is literature on healing ministry in the MCZ. The second section of the in-depth interview probed the possibility of inculturating healing ministry in the MCZ. The section asked questions such as the possibility, benefits and challenges of inculturating healing ministry (see appendix 7).

The use of in-depth interviews in this research proved to have some benefits. First, the interviews helped the researcher to create a conducive environment for the leaders in the three selected societies to share their experiences on healing ministry because the method is flexible. Second, in-depth interviews involve the researcher and the participants – the researcher was engaging in actively asking questions and listening to the participants as they also listened to each other's contributions (Kothari 2004:98). Third, in-depth interviews allowed the participants to use their own language, which made the discussion very fruitful. Fourth, the language of the interview was adapted to the educational level of the interviewee (Kothari 2004:98). The three selected societies, as argued earlier, are from the low density, peri-urban and high density areas. The geographical location of these participants also had a bearing on the participants, resulting in the findings being valid because they were coming from different life contexts. The educational levels of these respondents is represented by their milieu, with those from low density being highly educated with some participants having Honours, and Masters Degrees, while others had PhDs. This situation was in contrast to those in Epworth in particular, some of whom did not have a recognized academic qualification. Those in Mbare were a mixed group of the educated and non-educated. This situation obviously had a bearing on the level of articulation of the healing ministry phenomenon. However, these diversities among the participants presented a balanced, deep and rich meaning of healing ministry in the MEM societies.

7.4.2 Focus Group Interviews

Focus group interviews are a method in qualitative research in which attributes, opinions or perceptions towards an issue, product, service, or programme are explored through free and open discussion between members of a group and the researcher (Kumar 2011:386). Kumar further argues that a focus group is a facilitated group discussion in which the researcher raises issues or asks questions that stimulate discussion among members of the group and

the significant points raised during these discussions provide data to draw conclusions and inferences (2011:386). The focus group interview was used on the assumption that this method of soliciting data is effective in giving a voice to marginalized groups of society, the poor, women or children (Liamputtong 2012:7). Focus groups are rich because they allow the researcher to interview and observe at the same time. Kumar calls this qualitative technique (2011:386). The importance of using focus groups was succinctly expressed by Taddlie and Tashakkori as it is a process that allows access to content that the researcher is often interested in, the attitude and experiences of the informants (2009:227). In this missio-cultural study of healing ministry within MEM societies, focus group interviews were used to gather data from four groups of ordinary members of the three selected churches. These are the youth, the privileged and the less privileged members of the MCZ.

The use of focus groups interviews benefitted the study especially as the researcher was able to identify the language, definitions and concepts that the research participants find meaningful as they navigate through their daily life experiences with the healing ministry within MEM societies (Ferm 2001:12). Given that in-depth interviews were first conducted with the church leaders, the focus group discussions were used as follow-ups to verify individual interviews' data from the MCZ bureaucracy. Focus groups also help to identify how individual responses differ in a group setting (Liamputtong 2011:7). Going by these merits, it made sense for the researcher to start conducting in-depth interviews with the society leaders who are the custodians of the church, then later engage ordinary people to hear from their side, thereby verifying facts.

The number of people who participated in the focus groups has been summarized in tables 2 and 3. The participants were homogeneously drawn from different levels of education. The participants include those who are now worshipping at Christ Embassy, and the couple who are back to MCZ but when they moved out, they worshipped in five different Pentecostal churches within a period of three years. After leaving the MCZ, the couple worshipped at Celebration Church, United Family International Church (UFIC), Impact Church, Kingdom Members, and Gracious Anointing Ministries. The other participant was a woman who is now a "prophet" in *Johane Masowe yeChishanu*¹¹³ church, which is one

¹¹³ Johane Masowe Church was founded by Shonhiwa Masedza in 1932 after he became ill and he "died" then later "resuscitated". Masedza was a member of the United Methodist Church and after his "resuscitation he changed his name to Johane Masowe, meaning John of the Wilderness" (Ranger 2008). After his death, his church split into different groupings namely Johane Masowe yeChishanu, Johane Masowe Saturday, Johane

the fast-growing AICs in Zimbabwe (Mukonyora 2007; Engelke 2007). Moreover, there was a female youth, now fellowshipping with UFIC. In addition, a couple who have transferred to the United Methodist Church (Linden and Weller 1984) also took part in the interview; the same with two former MCZ couples, one with UFIC and the other with PHD ministries. In summary, the former Methodists who were interviewed are a rich combination of four couples, one independent man, one woman and two youth, a male and a female. The advantage of having these informants using the snowball sampling was that all of them had rich first-hand information, through their experience with the healing ministry in the MCZ, which might have forced them to move out.

During the interview process, snowball sampling allowed the researcher to reach the population that would be difficult to sample when using other sampling methods (Donalek 2004:25). Snowball sampling also allowed studies to take place where otherwise it might be impossible to conduct any research because of the lack of participants (Donalek 2004:25). The approached former Methodist members consented to the interviews and recording, and signed the informed consent forms. Although these interviewees brought a lot of diversity to this study, there were challenges along the way. First, it was not easy to identify these former Methodist members since others would not respond to my calls. Second, they were all interviewed at their homes, which was very expensive in terms of travelling. Third, some of members, especially those from Mabelreign and Epworth, refused to join others for the interviews, thereby making the focus group interviews to be conducted with either a couple or an individual.

7.4.3 Unstructured Interviews

The research on missio-cultural examination of healing ministry within MEM also benefitted from unstructured interviews or open-ended questions. These are interviews conducted without a structured guide; instead, the interviewer builds rapport with respondents, getting respondents to open-up and express themselves in the framework they choose (Crabtree 2006; Herbert *et al* 1996:78). Open-ended questions were used to interview health personnel at Epworth, namely Tamary Dende, the Sister in Charge, and Netsai Maruva, the first Nurse at Epworth in 1977 when it was reopened. In addition, former

Masowe UK, Johane Masowe *yeNguwo Tsvuku*. Today the church has a total membership of over six million congregants; they are known for not reading the Bible and majoring in healing ministry (Mukonyora 1998; 2007; Shoko 2007; Engelke 2007; Ranger 2008).

Methodists like Claudius Matsikiti, the former Methodist Minister, Bishop and Connexional Evangelism Coordinator now the founder of Harvest Apostolic Ministries (see chapter 5) were also interviewed. Furthermore, Seaward Makwara, the former Synod Secretary of Marondera District during the controversial Mutare Crusade where Chombo and Matsikiti are argued to have launched their churches (see chapter 5), and Chikwape who was the superintendent of Eden Chombo when he was disciplined and eventually formed his own church Revival Fires Apostolic Church (see chapter 5), proved very important in the interviews. In the same vein, Gamuchirai Gerema, the successor of Eden Chombo in the Revival Fires Apostolic Church, also took part in the unstructured interviews.

The purpose of using open-ended questions is because they had an advantage of allowing the respondents to express their thoughts and feelings in their own words instead of the words chosen by the researcher (Herbert *et al* 1996:78). The assumption guiding this type of interview was that the “unstructured interviewing is recommended when the researcher has developed enough of an understanding of a setting and his or her topic of interest to have a clear agenda for the discussion with the informant. In spite of having information, the researcher still remains open to having his or her understanding of the area of inquiry open to revision by respondents; unstructured interviews come to fill in the gap” (Crabtree 2006:56). Following the in-depth and focus group interviews, it became evident that there was a need to interview these individuals in order to find out how medical healing and healing ministry theology developed in the MCZ. The other purpose of engaging these participants was that the open-ended questions permit the analyst to study their opinions on the medical and theological position of healing ministry in the MCZ (see chapter 5). Six participants were interviewed using this method. To summarise this section, all the interviews were audio-recorded. The permission and informed consent were obtained from the participants. In order to audio-record the interviews, the laptop, cell phone and iPad were used as back-ups for the audio recordings, which were finally transcribed.

7.5 Data Production through Literature

The documentary data was particularly valuable in answering questions about the historical and theological context regarding healing ministry in the MCZ. Marshall and Rossman (2006: 107) observe that, for “every qualitative study, data on the background and historical context are gathered” to understand the social phenomenon under study within its context. Thus, the documentary data generated was used to construct a historical and theological

context within which the research participants' understandings were to be understood. The religious archive is represented by the MCZ, while governmental archives are the National Archives of Zimbabwe (NAZ), both situated in Harare, Zimbabwe, and the Special Collections is the Seth Mokitimi Methodist Seminary (SMMS) Archives in Pietermaritzburg, South Africa (see appendix 9 and 12).

The first category of data was gathered from the archives. MCZ archives contain all minutes and account books relating to trust, conference, districts, circuits or society affairs when no longer needed for current reference in the conduct of business. These have been kept since 1891 when Methodism was planted in Zimbabwe. The archives are kept by the Methodist Connexional Bookshop at Number 7 Central Avenue, Harare, Zimbabwe. Pearce-Moses holds that religious archives contain information relating to the tradition of the faith organization or denomination (2006:213; MCZ *Deed of Church Order and Standing* 2007 item 113:33). Government archives contain material relating to local state or national or government entities (Pearce-Moses 2006:215), in this case for Mai Chaza and Paul Mwazha the former Methodist Church members during the missionary era (see appendix 8, 9 and 10). The archives are found in Borrowdale Road, Gunhill, Harare, Zimbabwe. Seth Mokitimi Methodist Seminary archives were also visited. The archives house a special collection for the material on John Wesley, like *Works of John Wesley*, his sermons, theology, Appeals and Minutes, Treaties and Journals (2006:215). The archives are found at 115 Golf Road, Epworth, Pietermaritzburg, South Africa (see appendix 10 and 11).

The second category of data was generated through reviews of published data available in books, journals, magazines, newspaper reports, reservoirs and articles. This literature was accessed from the University of KwaZulu-Natal and Seth Mokitimi Methodist Seminary library. Moreover, some of the search engines used include: Google Scholar, Ebscohost, Research Space, Peer Reviewed Journals, and other Databases on CD-ROM or Online for journals. Articles and other relevant books, journals, and theses have also been hand-searched for this missio-cultural examination of the healing ministry within MEM of the MCZ. Special consideration was given to materials under arts, humanities and social sciences (Mouton, 2009:206). The use of these resources helped this research to identify the research gap that needed to be bridged by this study. The secondary sources included Methodist scholars like Thorpe (1951), Zvobgo (1991), Banana (1991), Madhiba (2000, 2010), Mosley (2007), Gondongwe (2011), Makoti (2012), and Mawire (2015) who

presented the rich historical background of Methodism and partially addressed healing ministry.

7.6 Process and Method of Data Analysis

There are a number of different methods applied to analysing qualitative research data, such as content analysis, discourse analysis, comparative analysis and thematic analysis (Dawson 2002:155). According to Swinton and Mowat, data analysis is the process of bringing order, structure, and meaning to the complicated mass of qualitative data that the researcher generates during the research process (2016:57). For the purposes of analysing data of this missio-cultural examination of the healing ministry within MEM societies, the researcher employed thematic data analysis and discourse analysis as tools, where the interviewed people's statements were coded and classified in themes in relation to the focus of the study.

7.6.1 Thematic Analysis

Two methods of data analysis have been employed in this research. The first one is thematic data analysis. Thematic data analysis seeks for themes, which are the dominant features of the phenomenon under study, across all types of qualitative data analysis (Teddle and Tashakkori 2009:252). The two scholars' further state that most qualitative data analytic techniques involve regenerating themes that evolve from the study of specific pieces of information that the investigator has collected (2009:252). Using the argument of the two scholars, it justifies the reason why the data processing of this research engaged thematic analysis. The fact that this was a qualitative research study, thematic analysis as a process of encoding qualitative information benefitted this study, given that the method involves finding dormant themes that are emerging from the data or the phenomenon (Boyatzis 1998: VI; Teddle and Tashakkori 2009:252). Thematic analysis has been identified because it is flexible and it can be easily applied to the investigated phenomenon of healing ministry (Clarke & Braun 2013:27). In view of this assertion, the healing ministry phenomenon researched in this missio-cultural study was grouped into themes and subthemes of healing and inculturation of the healing ministry. The themes were drawn from the interview transcripts and were based on common themes from the participants (Braun and Clarke 2006:27). The data was then analysed and described in rich detail in the following chapter. This process of analysis came after the reading and re-reading of the transcripts that were

transcribed verbatim, in order to gain the meaning of the healing ministry within MEM societies of the MCZ.

There are two advantages of reading more than once. Teddie and Tashakkori state that in reading and rereading, we immerse ourselves in the data, taking notes on material we consider significant, highlighting comments that seemed to capture the essence, phenomenology, plotlines and code. This process leads to the identification of initial themes (2009). Through transcribing, themes such as healing ministry and inculturation themes began to emerge. The second advantage is stressed by Hardicre who points out that reading and rereading becomes the basic method to enhance the validity of research such that it reflects the original data (2014:539). The researcher built some valid arguments to support these themes from the data of the healing ministry phenomena within MEM societies of MCZ. When the literature is interwoven with findings, the story that the interviewer constructs is one that stand with merit (Hardicre 2014). The formulation of themes within the research means identifying the recurring messages from the interviews. The theme is a pervasive quality that tends to permeate and unify the situation (Teddie and Tashakkori 2009:252). Both the in-depth and focus group interviews that were coordinated rigorously followed the analytical procedure proposed by Braun and Clarke (2006), summarised in table 4 below into themes and subthemes:

Theme	Subtheme
Healing Ministry	Divine healing Faith healing Medical healing Sacramental healing Healing through pastoral care and counselling Exorcism and deliverance Music as a source of healing Prayer
Inculturation of healing ministry	Natural Healing Cultural Healing

Table 4- Themes and subthemes from the in-depth and focused group interviews

7.6.2 Discourse Analysis

The second data analysis method used in this missio-cultural examination of healing ministry in MEM is discourse analysis. According to Johnstone, “discourse is a focus of study in most of the humanities and social sciences, and discourse analysts set out to answer a variety of questions about language which includes sociocultural processes that surround and give rise to discourse” (2017; see also Wodak & Chilton 2005:xvi). Discourse analysis also emphasises the way the version of the world, society, events and inner psychological worlds are produced in discourse (Silverman 1997:146). In using discourse analysis, the theological world of the MCZ members in MEM society on healing ministry was constructed in view of how the participants understood the phenomenon (1997:146). One of the purposes of using discourse analysis is that it has an analytic commitment to studying discourse as texts and talks in social practices, thereby making it an analysis of what people do (1997:146; Wodak & Meyer 2009). The two interview methods whose participants were randomly and chain-reference selected brought to light how healing ministry is perceived in MCZ in general and MEM in particular, through the discourse of these samples.

One of the themes emphasised by discourse analysis is the rhetorical or argumentative organization of talks and texts, claims and versions constructed to undermine alternatives. Such rhetorical organizations of talks came out clearly, as the different groups were asked the same question in order to ascertain the validity of the theological claim on the healing ministry in MEM (see also Richards 1999). The assumption guiding the use of discourse analysis is that the procedure used to arrive at claims is often quite different from the way those claims are justified (Silverman 1997:147). In order to come out with the same sample, discourse analysis presented questions that the research was trying to answer through interviews with church leaders and ordinary members of the church in MEM, on how they perceive healing ministry in the MCZ. The advantage of using discourse analysis is that it provides different procedures such as interviews. “Instead of treating interviews as machinery to harvest data from respondents, interviews are viewed as arena for interaction in its own right” (Wodak and Chilton 2005), which is what Silverman calls “natural-interaction-in-interview” (1997:147). This method demonstrates that the data collected through interviews was voluntarily and freely given with all confidence by the participants.

7.7 Validity and Trustworthiness of the Study

Any research that is undertaken must prove its validity and reliability. Trustworthiness refers to consistency, stability or repeatability of the results from the study (Christensen 2007:205). Validity and trustworthiness are therefore necessary in the in-depth, focus group interviews and observations in order to enhance conclusions from the research.

7.7.1 Validity

According to Jupp validity aims to produce the same results even if the interview is done by another researcher (2006:1). It is the one that produces results that are both reliable and valid (Christensen 2007:206). Although it is complex to define validity in its simple terms, the term however refers to the researcher's dependence on or confidence in something (Richards 2014:141). In the context of this research, the validity of the contribution of the participants on their understanding of the healing ministry within MEM was supposed to be strong, such that any researcher could use the same data for another research study. This answers the reason why the same questions were asked during the in-depth and focus group interviews. Allbutt, Amos and Cunningham-Burley present three potential threats to validity of data from the focus group, namely, compliance, identification and internalization. The three scholars underscore that compliance occurs when the informant responds in a way that he or she feels the question expects. This response might necessarily not be the correct answer in reference to the discussion being carried out (1995:445). Identification is when a respondent provides answers similar to persons he/she is personally attracted to. If the respected person happens to be in the focus groups, what becomes clear is that the answers of the whole group will be slanted toward this individual. Such a person becomes the think-tank of the group by default (Allbutt, Amos and Cunningham-Burley 1995:445). Internalization refers to deeply ingrained opinions that are personal and less susceptible to group influence (1995:445). The three points are common in research and can neutralize its validity.

As a way of combating the three factors, Allbutt, Amos and Cunningham-Burley maintain that opinion formation and change occur naturally through group discussions. In a focus group, the researcher or the moderator may disrupt this natural process because of the respondent's desire to comply with the moderator's expectations (1995:446). For the information from the participants to be valid, the participants must be independent (Ferm

2001:62). In order to verify the validity of the data, drawing from the three factors raised by Allbutt, Amos and Cunningham-Burley, the researcher was able to note these attempts, thereby providing the group a climate that allowed individuals to express and defend strongly what they held as their beliefs and opinions on their understanding of the healing ministry within MEM societies of the MCZ. The ability to unseat deep-seated theology made this research on healing ministry within MEM very rich.

7.7.2 Trustworthiness

According to Thomas, reliability refers to the extent to which a research instrument such as a test will give the same results on different occasions (2009:104). Although Thomas is right in using the word reliability, the researcher feels that the qualitative data is gathered on trustworthiness more than reliability and as such trustworthiness will be the ideal word to use in this research. The trustworthiness in data gathering, especially from focus group interviews, is for the researcher to identify a particular seating arrangement for the group (2001:228). Riding on the same point, the researcher organizes the informants to sit facing each other in a cyclical formation. This seating arrangement allows every member to feel equal and the aspect of inferiority and superiority is also averted. Moreover, the researcher also allows every group member to share on the topic. In this missio-cultural research on the healing ministry within MEM, the introverts and the extroverts both contributed to the validity and trustworthiness of the study. The trustworthiness of the data was also tested by interviewing the same class of people in different societies. In addition, most of the questions that were asked of the superintendent during the in-depth interviews were also asked with the stewards, RM and MCU leaders. In the same vein, the questions that were asked with the youth in the focus group were also asked with the privileged and the less privileged and the former Methodist members. This exercise helped the missio-cultural examinations of the healing ministry within MEM to have a balanced discourse, allowing the research to be reliable (Thomas 2009:105). Furthermore, the same theme of healing and inculturation cut across all interview groups, both in-depth and focus groups, thereby bringing reliable responses.

7.8 Methodological Limitations

This research on missio-cultural examination of the healing ministry within MEM has seven limitations that the researcher has observed.

- First, the research has only concentrated on three societies of the MCZ. Mabelreign society is in a circuit with a total of seven societies and only one was selected. Moreover, Mbare society is in a circuit with three societies and only one society was selected. The two societies are in Harare West District of the MCZ. Furthermore, Epworth society is in a circuit with seven other societies. Epworth circuit is in Harare East Districts. The fact that the research randomly selected societies in circuits with many other societies makes the research limited.
- Second, MCZ has a total number of eight districts and only two were selected. Using Harare East and West where the three societies are located as examples, one will find out that the three societies were not a representation of the MCZ population. For example, Harare East alone has seventeen (17) circuits and one hundred and seventy three (173) societies (MCZ Handbook 2017:88-91) and yet only one society was selected. Harare West District where two societies were selected, has twenty-three (23) circuits and one hundred and fifty-eight (158) societies (MCZ Handbook 2017: 91-94). A random selection of the two districts has shown that there are forty circuits and three hundred and thirty-one societies (331) in the entire MCZ, thereby making the sample a misrepresentation of the Methodist theology on the healing ministry.
- Third, MCZ has membership from all sixteen languages¹¹⁴ of Zimbabwe. However, the research has identified the Shona ethnic group in Harare only. It is important to note that the Shona language has five dialects¹¹⁵ which also make the sample problematic.
- Fourth, the time management during the interviews was not consistent. At times the interview would start late because the participants would not have arrived. In some instances the interviews would take more than an hour, thereby posing challenges to the other appointments scheduled on the same day.
- Fifth, the researcher conducted the research from Pietermaritzburg, South Africa, which is almost two thousand kilometres from the research area in Harare,

¹¹⁴ According to the Constitution of Zimbabwe adopted in 2013, Zimbabwe has sixteen language with English being the common language. The major languages are Shona and Isindebele. The other languages are Chewa, Chibarwe, Koisian, Kalanga, Nambya, Nda, Shangani, Shona, Sotho, Tonga, Tswana, Venda and Xhosa (Ilaanga Lodge 2016).

¹¹⁵ "The Shona language is spoken by over 10 million people in Zimbabwe, most of them having it as their mother tongue. It is a Bantu language spoken in the country, as well as in Zambia and Botswana. Shona's different dialects include Manyika, Nda, Karanga, Zezuru, and Korekore. It is taught in urban schools as a subject and not as medium of instruction" (<http://www.studycountry.com/guide/ZW-language.htm>).

Zimbabwe. The geographical location was a hindrance because the researcher spent more time in the South Africa than in the researched country or area.

- Sixth, the travel cost to the field was very high since the researcher did not get any form of assistance for travels.
- The seventh challenge was posed by the researcher's role since he is both a member and a minister of religion with the MCZ. In addition, the researcher once ministered in Mbare and Mabelreign societies as the superintendent minister in 2007 and 2012-2014 respectively. This conflict of interest appears as a hiccup to objectivity and rigour of the study. In this scenario, it is easy for the researcher in this predicament to bring his preconceived ideas.

In a bid to deal with the above limitations, particularly the last one, the researcher used the insider-outsider approach to research. According to Robson (2002:297), it is increasingly common for researchers to carry out studies directly concerned with the setting in which they work. Questions that frequently arise for such researchers include: "What effect does the researcher's insider status have on the research process? Is the validity of the research compromised? Can a researcher maintain objectivity? Is objectivity necessary for validity?" (Robson 2002:298). Using the insider research, the concept of validity becomes increasingly problematic especially when the researcher is directly involved in the study; he/she will cease to be objective and the validity is also threatened. Rooney notes:

The list of questions on validity seems to cloud the insider researcher. Questions like; will the researcher's relationships with subjects have a negative impact on the respondents' behaviour such that they behave in a way that they would not normally do, will the researcher's knowledge lead participants to misinterpret data or make false assumptions? Will the researcher's insider knowledge lead the informants to make assumptions and miss potentially important information? Will the researcher's politics, loyalties, or hidden agendas lead to misrepresentations? Will the researcher's moral, political, cultural standpoints lead them to subconsciously distort data? (2005:6).

Although there seems to be some challenges for the insider researcher, objectivity remains the primary goal of the study. Being an insider in the missio-cultural study of the healing ministry with MEM allowed the researcher to have a wealth of knowledge which the outsider is not privy to (Rooney 2005:6). It is argued that interviewees may feel more comfortable and freer to talk openly if familiar with the researcher who is an insider than an outsider (Rooney 2005:7), in which case, this was an advantage for the researcher. Rooney further argues that from an anti-positivist perspective, insider research has the potential to

increase validity due to the added richness, honesty, fidelity and authenticity of the information acquired. The arguments surrounding insider research and concepts of validity are complex, but above all, the insider remains very relevant to do the study (Rooney 2005:7).

In this missio-cultural study of the healing ministry within MEM, the researcher would not be out rightly declared as an insider researcher, first, because the research itself was an academic gap that was actually realized by the researcher as an insider. Second, the past relationship with the congregants created a conducive environment for discussion during interviews. Third, the fact that the researcher was no longer an active minister in any of the two societies made him neutral to the research area. Fourth, the research was conducted in Harare, Zimbabwe while the researcher was staying in Pietermaritzburg, South Africa and this justifies the researcher as an outsider prepared to come out with objective findings. Fifth, the researcher did not research as an independent but was given permission by the gatekeepers (see appendix 2 and 3). This permission to carry out this missio-cultural study of healing ministry within MEM societies of the MCZ also made him an outsider, thereby validating the research findings.

7.9 Ethical Considerations

The ethical considerations in any research are normally contained in the informed consent, which is the major ethical issue in conducting research (See appendix 4). It is one of the means by which the respondents' rights to autonomy are protected (Beauchamp and Childress 2009:99). According to Sudensha and Datt (2016), any researcher needs to adhere to and promote the aims of the research imparting authentic knowledge, truth and prevention or error. In view of this point, ethical consideration in research has always played a pivotal role in responding to these gaps in research. All the participants were advised that their participation in the missio-cultural healing ministry within MEM was entered into voluntarily and willingly (Fouka and Mantzourou 2011:4). According to the principle of Fouka and Mantzourou, the participants were also advised that it was their right to withdraw from the research process any time they felt like doing so. They were also made aware that it was their right to be protected from physical and mental harm or suffering and death as a result of this research on the missio-cultural healing ministry within MEM (Burns and Grove 2005:14). The reason for advising the participants of this information was because the protection of the respondents in research and their well-being is more important than the

needs of the researcher (Oddi & Cassidy 1990:21). It is against this background that during the interview process, the researcher gave the participants informed consent letters to consent to their willingness to participate. In addition, the researcher informed the participants that they needed to read and understand the ethical considerations because they were going to be protected by them through anonymity and confidentiality in both their names and contributions. In emphasizing the contribution of the participant, Oddi and Cassidy observes that the researcher may insert the “non-coercive disclaimer” which states that participation is voluntary and no penalties are involved in refusal to participate (1990:24).

The reasons for allowing the participant to withdraw anytime are varied. First, the informant might be having other programmes; as such the researcher should not hinder their plans. Second, there are times when the participant feels uncomfortable with the research questions and maybe he/she is being interrogated inquisitively. It does not help the participant to remain in the interview when in an actual sense that person has already closed their mind to the research. Third, the informant might not be well-versed with the area being investigated, thus pushing time during an interview might also be unethical. Fourth, the respondent might also feel that his/her responses are not being respected by the researcher; as such withdrawing becomes the best solution. However, in spite of these clear reasons that could make the participants to withdraw anytime, all of them did not leave before the completion of the interviews, which ranged between twenty-five minutes to two hours.

The participants were also advised that their participation was for free and voluntary (Silverman 2006:157). Given the number of people who are doing research, if participants are being paid, the research will have to be very expensive and yet most students live on bursaries. The research would also be compromised for material benefits. The participants in the missio-cultural understanding of the healing ministry within MEM societies were also told that their confidentiality was guaranteed and their inputs were not to be attributed to them as individuals but reported only as a population member opinion (Fouka and Mantzorou 2011:5). The ethical consideration also explained to the participants that the research findings were going to be kept with the supervisor for five years according to the statutes of UKZN (see ethical clearance appendix 1). These explanations made the researcher to have the buy-in and interest from the participants in the missio-cultural

understanding of the healing ministry within MEM and how the phenomenon might be influencing their society.

The participants not only consented to the interviews, but also to audio recording. In order to give credibility to the study, the researcher used the official names of the church leadership as they were speaking on behalf of the church. However, the focus groups demanded the coding because they were the ones speaking from the margins of society. The researcher used 'pen names' for most of the respondents. Where consent was granted, the real names were used (Mapuranga 2010:17). In this missio-cultural study on the healing ministry within MEM societies, former Methodist members who were interviewed as individuals were given pseudonyms which were randomly selected.

According to Mouton, random samples are unbiased because every member has an opportunity of being selected (2009:138). The rationale of giving pseudonyms was clearly put across by Liamputtong who mentions that researchers are ethically required to make attempts to ensure anonymity and confidentiality of the participants. This anonymity is not just a promise, but even online anonymity must remain as such (2011:28). Liamputtong states that "in social qualitative research, a researcher may make use of pseudonyms as a means of preserving the identities of participants in virtual focus group research reports or publications" (2011:28). In this research, the names of the former ministers were used. The researcher should caution that the name of the group had nothing to do with the character of the late minister but it was only a way of avoiding letters or coincidentally some of living people's names to be implicated in this missio-cultural study of the healing ministry within MEM societies. In addition, these ministers were advocating for inculturation of the Methodist theology before their death (Banana 1991). Liamputtong reiterates that "real names, user names, domain names and signatures can be adjusted to distinguish the true identity of the participants" (2011:28). The selected late ministers were once leaders before and after the autonomous MCZ in different districts of the Methodist Connexion.¹¹⁶

Stewart, Shamdasani and Pock confirm that there is no particular name that can be used as pseudonyms (2009:602). In their presentation, they used names like Red Beijing, Red Australia and Yellow Beijing (2009:602). Drawing from these scholarly examples, naming

¹¹⁶ According to the MCZ *Deed of Church Order and Standing Orders 2007*: Section 10:101. P. 29 "Interpretation" the term Connexion refers to the Methodist Church in general.

the groups by the names of the late ministers was not unique, rather it was relevant, valid and theological and it puts the research in the context of the MCZ theology. In addition, the randomly selected ministers served in the MCZ, attempting to inculturate the church to the best of their ability in a religiously contested Zimbabwe (see also Gondongwe 2011). Although the three groups had pseudonyms, the youth focus groups maintained their names; for example, Mbare youth or Epworth youth. In taking this route, the researcher took extra precaution not to quote the youths of any given society as individuals but as representing the group and this way maintained their anonymity (Liamputtong 2011:28). The table below shows the pseudonyms that were given to the focus group of the privileged and the less privileged and the former Methodists participants as a way to protect their integrity.

Society	Focus Group	Pseudonym
Mabelreign	Privileged	Andrew Ndhlela Group
	Less privileged	Caspen Makuzva Group
	Former Methodist Couple	Adam and Rudo Jack
	Former Methodist youth (male)	Thomas Santosa
	Former Methodist man	Ian Cottshills
Epworth	Privileged	Crispen Mazobere Group
	Less privileged	Enos Chibi Group
	Former Methodist Couple	Jacob and Rachel Epworth
	Former Methodist youth (female)	Dorcas Muguta
Mbare	Privileged	John Jabangwe Group
	Less privileged	Enias Mandinyenya Group
	2 Former Methodist Couples	Mr and Mrs Mbare and Mr and Mrs Highfield (not real names) were named (Julius Juru Group)

Table 5: Pseudonyms of focus group interviews and former Methodists

7.10 Conclusion

The chapter has deliberated on the research design, methodology and the methods that were used in the missio-cultural study of the healing ministry within MEM societies. The research design, access to the research project and methodology were expounded. The chapter also elaborated on the phenomenological method, its definition, strengths, weaknesses and the justification of its use in this project. In addition, the researcher also expounded on the research methods and instruments used in the project. The methods of data collection, such as in-depth and focus group interviews, were expatiated. Each method was defined, elaborated and analysed. Furthermore, the research also highlighted areas where each method of data collection was used. On one hand, in-depth interviews were used to elicit data from the leaders of the church who include the superintendents, stewards, RM chairwomen and MCU chairmen of the three societies. On the other, focus group interviews were employed with the less privileged members of the church. These church members felt comfortable to speak in groups and they encompassed the youth, the privileged and the less privileged. The focus groups were also supposed to be used with the former Methodists, however, only one group from Mbare was interviewed. Others were either interviewed as individuals or as couples. The challenges faced were explicated. The data was also drawn from participants through unstructured interviews, observations and literature analysis.

In addition, the chapter has also identified some of the late Methodist ministers who were used as group leaders of the privileged and the less privileged focus groups. Their names became the pseudonyms for these privileged and the less privileged focus groups. The researcher cautioned that the characteristics of these ministers had nothing with the group that each one was named privileged or less privileged however, the purpose was to draw the research to the context of the MCZ quest for gospel inculturation by some of the said leaders. Moreover, primary and secondary data were also explored. The section discussed how existing data was gathered from the internet, libraries and archives. The chapter also went on to discuss the ethical considerations of the study, elaborating on the signing of consent forms. Likewise, the process of transcribing data and the use of thematic analysis was discussed and themes on healing and inculturation of the healing ministry were highlighted. Furthermore, the researcher delved into the validity, rigour and trustworthiness of the study of the study, and concluded with the methodological limitations. The next chapter will deal with data analysis and the presentation of data.

CHAPTER EIGHT

DATA PRESENTATION AND ANALYSIS

8.1 Introduction

The previous chapter discussed the research design, methodology and the methods that were used in this missio-cultural study of the healing ministry within MEM societies of the MCZ. The chapter also deliberated on the phenomenological method, its strengths, weaknesses and the justification for its use in this project. The research instruments used in the project were also explored. In addition, the chapter analysed the methods of data collection, like semi-structured and focus group interviews. The major themes were divided into subthemes that will inform this chapter. This chapter will present and analysis the data that was collected from the participants' understanding of healing ministry in MEM. Different definitions of healing ministry in MCZ presented by the church leaders and the ordinary members of the MCZ will be delineated. The chapter will analyse the social and cultural factors that were highlighted in chapter six in view of the participants' understanding. Different methods of healing in the MCZ, such as divine healing, faith healing, medical healing, sacramental healing, exorcism and deliverance, prayer and music as a source of healing will also receive attention. The chapter will also go further in analysing the participants' views of the possibility of inculturating healing ministry and conclude by investigating the challenges posed by variances in understanding healing ministry in MEM.

8.2 Understanding of Healing Ministry in MEM Societies

This section will present the understanding of healing ministry in MEM as it is understood first by the church leaders, and second, by the ordinary members of MCZ.

8.2.1 Definition of Healing Ministry by the Church Leaders of MEM Societies

The findings demonstrate that there are variances in the understanding of healing ministry in the selected societies of the MCZ. According to the Superintendent of Epworth society, Rev Victor Chakanya, "healing ministry in the MCZ is the receiving of salvation by individuals on condition they have faith in the ministry" (Chakanya 2016). The steward of Epworth Society, Mercy Nota, agrees with Chakanya's understanding of healing ministry. She states that, "whenever there is a healing service especially during Easter programmes or all night vigils, many people come for healing, however they only wait for the healing

service to end before they leave for bedding. Those who need counselling are the ones who remain behind” (2016). The contribution of Chakanya and Nota however differs from the Superintendent of Mbare society, Rev Victor Chidzambwa, who argues that “healing ministry in the MCZ means prayers for different ailments and spirits” (2016). Chidzambwa’s point was reinforced by the Mabelreign Society Stewards Stanley Mandizha and Tichaona Viyazhi who claim that, “healing ministry in the MCZ is the service offered to church members that addresses both their physical and spiritual needs. Physically, individual people are healed through prayers and healing is the major reason why they worship” (2016). This point agrees with Echema’s submissions that people flock to the healing ministry and prayer houses in search of solutions to their various problems, which could be spiritual, psychological, emotional or even economic. These range from diseases, psychosomatic illness, barrenness, to protection from enemies and the fulfilment of their ambitions and hopes (2006:15).

Mbare Society Steward Erikanos Mupakwachena agrees with his Superintendent Chidzambwa, and Mabelreign Society Stewards Mandizha and Viyazhi. In his statement, Mupakwachena argues that “healing services are for helping those who are not feeling well or those with burdens” (2016). Analysing these definitions, one notes that first, healing in the MEM societies could be “received”, suggesting that there is someone offering it. Second, healing is holistic; it caters for both the body and the soul. The Superintendent of Mabelreign, Rev Kudakwashe Paradza decided not to dwell much on the meaning of healing ministry but was quick to acknowledge that it has been part of the mission of the MCZ since the coming of the denomination in 1891. “As the word was being preached, healing has always taken place. Today healing starts the moment one enters the first step into the church for worship” (2016). This definition was reinforced by Chidzambwa, who sees the church as a sanctuary where all problems of life are addressed (2016). An interrogation of Paradza and Chidzambwa’s assertions presents two problems of healing ministry. First, healing ministry in the MCZ starts and ends in the church. Where there is no church service, there is no healing. Second, given the contested meaning of the word “church”, this argument remains problematic.

According to Chakanya, healing in the MCZ does not just happen, but can be performed during some specific programmes. Whenever there is a healing service, especially during Easter or all-night programmes, many people come to be delivered” (2016). Following

Chakanya's argument, healing ministry in the MCZ is conducted sporadically thereby making its understanding in MEM inconsistent. Since healing is a programmed phenomenon, it therefore means that some people deliberately attend or are unable to attend the Easter and all-night vigil programmes. Those who miss will not receive the gift of healing for a whole year and yet church services are conducted every Sunday. Given these challenges, through neglect, the MCZ in MEM deliberately exposes its membership to other healers who practice the ministry more often, thereby making dual membership evident. During the 2011 MCZ Annual Conference, the discussion on the issue of dual membership was very controversial. The lay delegates of MCZ Conference were caught between MCZ theology and the member's spiritual needs. One group had a feeling that dual membership was not a misnomer because members of the church 'simply go out' to other churches to get what they want and returned later, while the other groups argued that such behaviour is un-Methodist (MCZ Minutes of Conference 2011:24). Harare East District where Epworth society belongs also noted the impact of dual membership and brought a resolution to Conference that stated:

Taking note of dual membership that has escalated in the church due to the mushrooming of Pentecostal churches, there must be improved services in terms of teaching, preaching, spirituality and embedding deliverance services in an attempt to curb this phenomenon at its early stages (MCZ Minutes of Conference 2016:31).

The conference noted the resolution as a reminder to the assembly since the issue had been previously discussed in 2011. The same conference also received an achievement from Gutu Circuit ¹¹⁷ who reported among other things that they had started a midweek service which had attracted membership across ecumenical boundaries. They also reported about the launch of a healing and deliverance service on Sundays at 3pm (Agenda of Conference 2016:R25). Unfortunately, the conference did not deliberate on the theological implications of this ecclesiastical resolution. The fact that the issue did not appear in the Minutes of Conference means the resolution was endorsed by default.

Mabelreign Ruwadzano/ Manyano Thursday chairwomen Axulia Chipere maintains that "healing ministry is prayer for the people which is conducted by the minister and healing is only possible in the church because some individuals are able to confess their sins at the

¹¹⁷ Gutu is one of the MCZ circuits in Masvingo District whose minister is one of those interested in the healing ministry and he addresses himself as "prophet", a title which is contrary to MCZ theology (see MCZ Minutes of Conference 2014).

altar. However, it is not always the case that people go to the altar call for prayers. Some shy and they become stuck with their problems” (2016). The MCU Chairman of Mabelreign, Philemon Pasipamire, also argues that “healing is attending to the spiritual and physical needs in the community” (2016). Unlike his superintendent who narrowed down healing to the church, the MCU chairman extends it to the community. Chipere and Pasipamire mention the word “people” and not “members of the church”. These leaders feel that healing in the MCZ is the receiving of salvation by individuals if they have faith in that healing.

Chakanya and Nota’s responses seem to represent Epworth society – that healing ministry is a gift from God. The society MCU chairman of the same society, Gabriel Mazivanhanga, adds that “healing is a process, whereby the minister enquires the challenges of the sick individuals and allow them time to confess their sins after which the minister will pray for their situations” (2016). Mazivanhanga concurs that “healing sessions are programmed” (2016). According to Ruwadzano/ Manyano chairwomen of Epworth, Rebecca Mudzamiri and Muriel Molife, “healing is the process whereby the sick are healed from their ailments by the power of the Holy Spirit” (2016). Mudzamiri further states that “this healing is possible when one has faith”. Mbare society MCU Chairman Edmore Nhire buttresses the same point, arguing that “healing ministry is the process of making one well physically and spiritually” (2016).

When one analyses the definitions provided by these church leaders, two major groups became obvious. The first group is comprised of those conservatives who felt that healing starts and ends in the church. In any society, the conservatives are the custodians of institutions so that they remain intact. This group therefore speaks with the voice of those who want to maintain the integrity of the church at whatever cost. In this missio-cultural healing ministry research, this group feels that healing is only possible when it is being practiced by the clergy. The second group are those with who feel that the church has to change with the changing times. The liberal minded are those who have an understanding that healing starts from the community and the church is part of the community. This group is not very much about the traditions of the church, but that the church is a community in a community and should therefore fit in the larger family

According to Mokgabi “traditional African healing has been in existence for many centuries yet many people still seem not to understand how it relates to God and religion/spirituality. Some people seem to believe that traditional healers worship the

ancestors and not God” (2014:24; Murove 2009; Kasenene 2000). The traditionalist view is common in Epworth society while the conservative is prominent in Mbare society. Mabelreign has both the conservatives and liberal minds, with the Superintendent being an example of the conservative clergy. The coming together of people from these three areas of conservatives, traditionalist and the liberals enables the divergence and convergence of the healing ministry theology especially in this research. This in spite of the fact that a number of challenges emanate from the understanding of healing ministry from these three schools of thought. First, those who put the clergy at the centre of healing ministry contradict the Methodist theology of the priesthood of all believers. According to the MCZ *Deed of Church Order and Standing Orders*:

Methodist preachers, leaders and stewards in the household of God are shepherds of His flock. Some are called to this sole occupation and have a principal and direct part in these great duties but they hold no priesthood different in kind from that which is common to all Lord’s people and they have no exclusive title to the preaching of the Gospel or the care of the soul. These ministries are shared with them and others to whom also the Spirit divides His gifts severally as He wills (2007:2-3).

The second challenge is that a critical examination of the MCZ constitution demonstrates that ministry is for all who are called by God, not clergy only. Such a theological understanding by MCZ leaves each cleric excluding student ministers with an average membership of 1:485, thereby making healing ministry a demanding task with less manpower to address it simply because of having no interest on the part of the clergy or being overwhelmed by the mission for those who practice it.

The third challenge is that in a global world where the gospel is available on electronic media, MCZ members are exposed to other teachings that are contrary to the church’s theology. Although the teachings edify the spiritual life, the result is those who prefer to remain within MCZ, both lay and clergy, borrow these theologies and try to force them into the MCZ worship. Such an approach leads into the usual disharmony in the church (see also Minutes of Conference 2011 and 2014). Lastly, those who subscribe to the liberal route have the support of Wesley’s approach to healing ministry, which cuts across the needs of individuals more than one’s faith (see also Wesley 1747:vii; Health and Healing 2001). In the absence of a clear definition of healing ministry by the leaders of MEM, it is important to explore how the people in the margins of the church understand healing ministry in the MCZ.

8.2.2 Definition of Healing Ministry from the Underside of MEM Societies of MCZ

People from the underside of MEM societies, as argued earlier, refers to the privileged and the less privileged, the youth, and the former Methodist members who were interviewed through focus group interviews. The first group to be discussed are the “rich”. According to the members of the Ndhlela focus group (Mabelreign rich), “healing in the MCZ is both physical and spiritual” (2016). One member of the group stated that, “it is not easy to separate the physical and the spiritual being of an individual. Spiritual healing is divided into African and Christian spirituality. The African spiritual healing is the one that is associated with African traditional beliefs. Christian healing is associated with having faith in Jesus as the healer (2016). The other group member further argued that, “MCZ focuses on spiritual more than physical healing” (2016). The group bemoans the lack of physical healing in the MCZ, which has led to some members who are poor to suffer physically as the church is preaching about spiritual healing. Ndhlela focus group further argued that “spiritual healing has been narrowed to define what is healing in the MCZ thereby narrowing healing ministry from its real definition” (2016).

The Ndhlela focus group also scoffed at the church’s double standard of spiritualizing healing, and yet the theology of the church known through oral tradition condones exorcism. “Methodist has the spiritual healing that it focuses on and rarely targets the physical healing” (2016). Lessons that amalgamate the two forms of healing ministry are reluctantly presented, given the laxity of the theological policy on healing ministry with MCZ. This point was reinforced by the MCZ Conference when they resolved that, “the practice of making people vomit, go into ecstatic mood and run around in a place of worship needs to be addressed through teaching (2014:12). Furthermore, the group challenged the theology of exorcism in the MCZ healing ministry as mere tradition because the Bible has many accounts where exorcism was performed.¹¹⁸ Ndhlela focus group noted with concern and expressed that people who are possessed with evil spirits will be exposed to African spirituality because the church does not have a position on the healing of spiritual ailments” (2016). For this group, MCZ is divided into those who are comfortable with exorcism of demons and those who are not, and yet the Bible presents healing as both a physical and spiritual need. The group queried that “if the MCZ discourages exorcism, which is spiritual

¹¹⁸ See Mk 1:27, 34, 3:27; Matt 7:22, 8:16, 12:27; Luke 4:36, 6:7-18; and Acts 19:13-16 etc.

healing, and at the same time does not own a hospital, the church's understanding of healing ministry is questionable" (2016).

On the position of healing as exorcism, the Mazobere focus group (the privileged from Epworth) stated that "healing ministry is the time of praying and praising God and the sick are healed and demons exorcised" (2016). Unlike the Superintendent, the society steward and RM leaders of Epworth who argued that healing is only possible when there is a minister, the Mazobere focus group insisted that "healing is a gift from God which is given to anyone not only clergy because some of them are gifted in this area while others are not" (2016). The group added faith and confession as engines that propel healing ministry (2016). The Jabangwe focus group (the privileged from Mbare) argued that "MCZ should focus on spiritual healing because it is the answer to physical healing" (2016).

The second group that was interviewed were the less privileged from the three societies. Makuzva focus group (Mabelreign less privileged) agreed with the Ndhlela and Jabangwe focus groups that "healing ministry is the attending to the spiritual needs of members because in a number of ways spiritual illness affects the physical being" (2016). Chivi focus group from Epworth and Mandinyenya focus group of Mbare took the definition further to argue that healing is a process of counselling members of the church. These focus groups generally agreed on healing as attending to the spiritual needs of the individuals.

The third focus group represented the youth from the three societies. Mabelreign and Epworth youth generally agreed that healing is both spiritual and physical. However, Mbare youth went beyond this definition as they agreed with Ndhlela and Makuzva focus groups of Mabelreign that healing ministry is the exorcism of demons. The Mbare youth focus group further stated that "physical healing can be understood in view of African Religion that uses herbs" (2016). This is in contrast to the missionaries who medicalized healing ministry. "In the current MCZ, healing refers to faith healing and there are times when physical healing and faith healing cannot be separated because the spiritual healing might also affect the physical body" (Mbare youth focus group 2016). The group concluded that "healing thus comes from the body to the spirit through prayer; it involves the healing of the mind where an individual might need counselling in order to be healed" (2016). Mbare youth's definition agrees with Chitando and Klagba who maintain that "healing is a broad concept that refers to the restoration of health in every area of life, mentally, physically, emotionally, socially and spiritually" (2013:2). The definition also draws from Wesley's

theology that healing should be holistic. “Wesley’s holistic soteriology included not only an integrated approach to physical and spiritual health, but also the desire for the wellbeing of the entire community, particularly the poor and those without access to healthcare” (Ott (1991:44).

The fourth group of interviewees represented the former Methodists who defined healing ministry from both their previous experience with MCZ and their newfound faith. According to Juru Focus Group (Mbare former Methodist), “healing ministry is part and parcel of the fivefold ministries where some are called to be apostles, some teachers, some pastors, some evangelists and still others prophets” (Eph. 4:11). “Healing goes hand in hand with deliverance and is taking someone from a state of sorrow and anger to a state of joy and health and from sickness to health since healing implies that there are certain anomalies that have to be dealt with in the physical or in the spiritual life” (2016). The definition was confirmed by Rudo and Adam Jack (not real names, former Methodists from Mabelreign) as they stated that the sick are healed by the word of God only (2016). Thomas Santosa of Mabelreign (not real name) preferred to define healing as the fruit of the spirit (2016). In addition, Dorcus Muguta (not real name), a former Methodist from Epworth, understood healing ministry from two different traditions of MCZ and United Family Church International as a gift given to those who believe in God’s grace (2016). Likewise, Catharine Muzhayi (a former Methodist from Epworth), now prophet in *Johane Masowe yeChishanu Apostolic* sect, argued that, “healing ministry comes through hearing the word of God during the preaching of the sermon and the anointing of the sick” (2016). All other former Methodists from the three societies acceded that healing starts and ends with God. In view of former Methodists’ understandings of healing ministry, one notes that these former Methodists are informed by their new faith more than the MCZ faith, for example, where healing is defined as a transmission from agony to health. From all the definitions presented by Methodist leaders and focus groups, the role of faith was not very clear, thereby leaving the missio-cultural understanding of healing ministry in MEM ambivalent.

8.2.3 Healing Ministry at MEM Societies of the MCZ

In this section, the major focus is to analyse healing ministry in MEM societies specifically. According to Paradza, “MCZ’s mission cannot be effective without healing ministry, however, this ministry of healing has not been part of the MCZ’s mission strategy” (2016).

For Paradza, “MCZ is responding to some external forces to practice healing ministry thereby taking the church as a platform for solving personal problems” (2016).

Ndhlela focus group claimed that “healing ministry is rarely practiced at Mabelreign society to the extent that even if people present themselves before the alter call, there are no efforts by either the clergy or the preacher to take time with these concerned individuals” (2016). The group grumbled that, “instead of the minister to attend to the healing needs of the people, any member of the church from the congregation can be requested to pray a ‘general prayer’ and people will just go back to their pews. No counselling, no personal prayers and no follow up is done” (2016). The group condemned both the clergy and the preachers as forcing the members to visit other faiths because they have no solution to their problems. The group felt that “healing at Mabelreign is preached but not practiced” (2016). The claims of the Ndhlela focus group were challenged by Mr and Mrs Jack who averred that “the Word of God heals people even if they will be seated in their pews. It is not always the fact that people have to go to the alter call in order to receive the gift of healing” (2016).

MCZ leadership was accused by most former Methodist of anti-healing ministry. The first one to raise his voice was Ian Cottshills (a former Methodist from Mabelreign) who emphasised that “healing ministry in the MCZ is thwarted by the church leadership in their effort to glorify the historical Wesley more than God” (2016). Juru Focus Group (two couples from Mbare Mr and Mrs Highfield and Mr and Mrs Mbare)¹¹⁹ contended that “there are two groups in the MCZ, those pro healing and those who are anti-healing ministry. It is sad that those who are pro-healing ministry are easily displaced while those who are anti-healing are the leaders of the church” (2016). The focus group further stated that “healing in the MCZ is only practiced on some specific programmes and it is against this background that when people are asked about healing ministry, they confess ignorance that is it not part of the Methodist tradition” (2016). It is this challenge that creates a vacuum and conditions for dual membership. According to the couples, it is surprising that “although the MCZ inherited Wesley’s theology (see *MCZ Deed of Church Order and Standing* 2007:2), healing ministry remains strange to MCZ to the extent that even the one who prays for healing is shocked when the person is healed” (2016). Epworth youth focus group added weight to this discussion by claiming that “wherever alter calls are done, the results are very poor and yet people need tangible things” (2016). One has to note that from this analysis

¹¹⁹ The couple’s surnames represent the places where they stay and not their real names.

the delineations of healing ministry contradict what Paradza insinuated, that healing starts the moment one enters the church. Chidzambwa shared the same sentiments and went further to argue that, “the church is the sanctuary where grace and mercy meets” (2016). This tradition can be argued to have been inherited from the missionaries, who were convinced that every service is a healing service (Booth 1988:3). However, for MCZ, healing is for “some” services that are programmed.

For Ndhlela and Juru focus groups, healing ministry in the MCZ is programmed, thereby making it a church and not God’s programme (2016). Kelsey bemoans “that healing was simply dismissed, neglected and denied thereby making most Protestant Churches to take this negative route towards healing ministry” (1973:25). Chakanya agrees with Paradza that healing is “now” part of the MCZ mission strategy, as the societies are practicing healing ministry during gatherings and some special programmes (2016). Chakanya and Paradza’s argument represents a traditional school of thought; Chidzambwa, who comes from a liberal school, does not concede to this theology. He argued that “healing has always been practiced in the MCZ through sacrament of Holy Communion, prayers, counselling, laying on of hands and exorcism. More often, healing is part of the order of service where the preacher invites people to the altar call for prayer sessions” (2016). This statement was also confirmed by the researcher’s observation during the Sunday worship service conducted by a Local Preacher at Mbare society, where some church members responded to the altar call and the preacher prayed for them. This is in contrast to Chipere and Pasipamire and Mabelreign focus groups who claimed that nothing is done to the people who offer themselves to the altar call. Such actions confirm that healing ministry in MCZ depends on individual societies. Chidzambwa further argued that, “Mbare society has set aside every Tuesday for prayer and counselling sessions for the members who would have offered themselves to the altar call on a given Sunday worship service” (2016).

Although Chidzambwa did not give statistical substantiations, he claimed that “healing session at Mbare society has necessitated the increase in membership including some former Methodist members returning to MCZ” (2016). He further argued that “whilst healing is being practiced in the MCZ intermittently, its negative publicity is exacerbated by some reservations to talk openly about this ministry” (2018). In his opinion, Chidzambwa felt that MCZ should identify the new forms of worship so that the church may fit in the modern theological discourse. “One of these new innovations is the introduction of toll free lines for

healing sessions where members could be prayed for every time and healing and deliverance services televised” (2016). Unlike those ministries that are individually owned, Chidzambwa was not quick to suggest people who should lead such services, given the schism already experienced in the MCZ and the church’s position on healing ministry. Of importance to note is that although MCZ still grapples with its healing ministry theology, the church has agreed to the proposal to establish a television station for church programmes (MCZ Minutes of the Standing Committee 2017:3). Chidzambwa’s point was emphasized by the Jabangwe group from the same society who insisted that “the MCZ should introduce some healing schools” (2016). In their view, healing school prepare one to have faith in healing miracles.

Chidzambwa’s liberal assertion is supported by Masvanhise and Sankey who stated that “people who come for healing in the MCZ are invited to meet Jesus the healer and not the Missioner. The prayer for healing takes place within the context of the Body of Christ” (1989:19). The manual clearly indicates that Jesus in Luke 4:16-21 (cf Isaiah 61) states that “he was sent to proclaim freedom to the prisoners, recovery of sight to the blind, and release the oppressed. Those who were prisoners and the sick were set freed. Therefore the gifts of healing are given to the body of Christ – the church for the healing of sickness, physical, mental or spiritual” (:19). Chidzambwa’s point was also cemented by Presiding Bishop Ndhumbi who further stated that “healing and deliverance sessions in the MCZ should include components of pastoral care and counselling and there was a need to come up with a holistic approach to healing” (MCZ Minutes of Conference, 2015:4). However, Chakanya felt that for the traditionalists, like most of the members at his society, “healing is a cause of church’s downfall and has neutralised the identity of MCZ” (2016).

Jacob and Rachel Epworth (Epworth former members) succinctly put across the importance of healing ministry by stating that “a church that does not practice healing ministry is an incomplete entity because the ministry of Jesus was defined by healing. When the members move out of the church, they will blame MCZ for failing their faith” (2016). The couple further argued that “healing ministry demonstrates the church as a caring institution; as such, any individual who is healed in the church is encouraged and has confidence that there are people who care for those in need as Jesus did” (2016).

Mandizha and Viyazhi argue that “healing has always been practiced in the MCZ and this is evidenced by testimonies that are received every Sunday” (2016). For the two stewards, “although there are some church members who might not come back and testify their healing, this does not dismiss healing as a central ministry in the MCZ. What makes healing ministry unique in MCZ is that it is not emphasized or advertised” (2016). By not advertising healing ministry, the Jabangwe focus group feels that the “generality of MCZ ministers and preacher do not have faith in healing, such that any attempt to advertise it is disastrous because people will come and return without tangible things that point or convince them that God cares for the sick people like them” (2016). Ndhlela focus group concurs with the stewards of the three societies and Jabangwe focus group but goes further to argue that “John Wesley clearly defined the difference between spiritual and physical healing. Wesley was more Pentecostal than the church of today that discards Pentecostalism” (2016). The group highlights the fact that “MCZ approaches everything including theological issues methodically, forgetting the healing theology that defines Methodism. It is sad to note that MCZ congregants are charged with contempt and disciplined for breaking church regulations than breaking the biblical rules. This is the reason why healing is not emphasized in MCZ” (2016). Mazobere focus group of Epworth took it further to castigate the MCZ’s *Deed of Church Order and Standing Orders* as theologically retrogressive. They contemplated that “John Wesley defines a Methodist as a *homo librus* (person of one book - the Bible) (see Lloyd 2007:24) and yet MCZ anchors its mission with the *Deed of Church Order and Standing Orders* far more than the Word of God” (2016). Juru focus group claims that “the Church’s constitution is highly Euro-centric and is not able to address the African issues. African spirituality has no place in the Church’s policy book thereby making it a surrogate constitution for the missionary enterprise” (2016).

Still on the same point, Nota, an Epworth Steward, maintained that “healing has not been the mission strategy of MCZ because since it is not programmed, it is only during the dawn of newer Pentecostal churches around 2008 that it started” (2016). This point is also echoed by Mbare MCU Chairman Edmore Nhire. However, people in Epworth, most of whom are conservative, are not accepting the colourings done on the events in order to make healing ministry appealing to many. This point was first shared by the Epworth youth focus group who “scoffed that whenever healing ministry is practiced in the MCZ, the programme is done at midnight and some people will be sleeping” (2016). From an African perspective, these are the times when witches will be doing their ‘nocturnal perambulations’

(Chavhunduka 1978). The Mazobere focus group of Epworth felt that, “although the charism in the healing ministry is a new phenomenon, what is worse is when it was started, no efforts were made to teach people about the phenomenon. In addition, almost all connexional programmes that are disseminated to societies for RM, MCU and youth, none has any lesson on healing ministry” (2016). The RM leaders from the three societies generally agreed that healing ministry in the MCZ is a new phenomenon being driven by some external forces that include socioeconomic and religious contestation in Zimbabwe. Chipere and Pasipamire, and Mazobere focus group confirm that “healing in the MCZ was done through the tying of the R/M belts on the head of the sick person. The sick individuals who needed healing were also instructed by some church leaders to use the Bible and/or hymnbook as a pillow at night while they are sleeping” (2018). Chipere and Pasipamire and Mazobere focus group also believe that a person wearing an MCZ uniform was believed to have powers to heal and could pray for individuals and get healed (2016).

All the church leaders who were interviewed through semi-structured interview generally agree that healing ministry in the MCZ depends on one minister or the other. This answers the reason why the responses from Mbare society appear uniform, because the minister practices healing ministry. Chipere and Pasipamire added that “such ministers who practice healing are always known for their love for this ministry since they at times either overemphasize it or overdo it (2016). The situation is in such a way that when their names appear on the programme as invited preachers, be it Easter or an all-night revival, some members will be moved because they know the gifts of these ministers (2016). Some of the ministers pompously portray themselves as the “super ministers”, calling themselves the anointed ones and naming others as the holders of their mantles” (2016). This challenge was discussed in the 2013 MCZ Conference. The conference noted with concern that some ministers were displaying their healing gifts to the detriment of the MCZ’s mission. These ministers have started to change titles from the MCZ traditional title “reverend”, to apostle, evangelist, and prophet (Minutes of the Methodist Church in Zimbabwe Conference 2013:13). The 2013 Conference noted these developments with concern because the titles are contrary to the MCZ theology (:13). “The Conference tasked the District Bishops to address the issue. In assigning the bishops this task, the conference instructed them to deal intensively with the confusion that has characterized the church of late and reprimanded the concerned ministers” (:13). Such a harsh decision from the decision-making body of the church justifies that MCZ is not decisive with its healing ministry theology and thus dual

membership is rampant in the church as members move in and out of MCZ to seek for this scarce commodity.

The Mazobere focus group also highlighted that “healing ministry in the MCZ today is practiced by few ministers and as a result they are always invited by some societies and circuits” (2016). In contrast to RM leaders from the same society who spoke highly of these ministers, Mazobere focus group complained that “these invited ministers have a number of problems and they are actually causing a lot of confusion in the church” (2016). In the opinion of the group members, since most healing programmes are conducted on some specific events, like Easter, these ministers are supposed to be busy with their circuit. Unfortunately, they do not turn down the invitation from other circuits and as a result, they are overwhelmed, leading them to operate behind time. They arrive late and leave early because sometimes the venues of the programmes will be some distance from the other (2016). The group cited an example of a minister who was invited for healing and deliverance during the Easter programme in Mabelreign and other circuits 2016. The first venue was eight hundred kilometres from his circuit. The other was further, close to one thousand kilometres way (2016).

“In addition, as these ministers move around doing healing ministry, their circuits are left unattended with the members loitering like sheep without a shepherd. In order to cover up their programme, they rush up the healing sessions. The other challenge is, that invitation comes with appreciation and these ministers will have many programmes to boost their financial resources given the socioeconomic situation in Zimbabwe; such invitations are a way of augmenting the merger stipends” (2016). What is more disturbing as expressed by the Mazobere group is that “as they will be departing their ‘surgery’ (the healing session that they would have started) these ministers leave the session to either lay people or the ministers who in most cases will be reluctant to continue with the ministry. Members in need of healing will then further complicate the whole process by creating long queues on one ‘healer’, to their disappointment, because the minister will be rushing and they will not be able to see the ministers again; neither are they able to go and be prayed for by the caretaker healers” (the lay people or ministers of that circuit). In concluding their disappointment, the Mazobere focus group confirmed that, “members who are left in this state are easy targets for dual membership or lapsing” (2016).

Mandinyenya focus group also confirmed the statement that “healing ministry is a borrowed phenomenon” (2016) but since their superintendent Rev Chidzambwa is in support of it, members are beginning to appreciate the ministry. Mazobere focus group lamented that the fact that healing is borrowed, some traditional members from Epworth society have dismissed it as a Pentecostal theology. They also attacked some of the preachers who insist on healing ministry, arguing that this is not a Methodist practice. The group reached this decision after realizing that in the history of MCZ, those who practiced healing ministry like Mai Chaza, Paul Mwazha and Claudius Matsikiti, to mention a few, were anathematized as anti-Methodist (2016).

According to Chivi focus group, “the origin of healing ministry in the MCZ traces from the missionary era. When missionaries arrived in the current Zimbabwe, they medicalized healing ministry and left faith healing unattended”(2016). In the current MCZ, spiritual healing is relatively new, dating to 2008 (see Mangena and Mhizha 2013; Zimunya and Gwara 2013). The church attended to physical healing because they had a clinic at Epworth, which was operating from the minister’s house. People would go to the minister to be treated and a nurse was there to attend to people’s needs, but spiritual healing continued to suffer (see Section 3.4.4 Epworth Mission Clinic). Since healing was medicalized, the old ministers could listen to the orders and teachings of the missionaries on this instruction; however, the coming of the young and energetic ministers brought in the new globalized theology of healing in the MCZ (Chivi focus group 2016). Healing has come as a new phenomenon because of the socio-economic, political and religious environment that MCZ finds itself. Most members are transferring their faith to new Pentecostal Churches and AICs for healing. The motive behind the transfers was emphasized by Ukah who argued that “the newer Pentecostal churches use therapeutic substances like the blessed water and anointing oil. Although the use of water and oil is not unique to them, they are also common among the AICs and traditional healers” (2007:1-20). Chivi focus group claimed that “some of those who remain in the MCZ are also using anointing oil, water and mass prayer is proliferating in MCZ” (2016). One participant from Mabelreign youth gave an example of a church member whose child was not feeling well. During the healing session at an Easter crusade, the member was asked to bring her Ruwadzano belt. The minister prayed for the belt and gave it back to her so that she would tie it on the sick child. After two days, the child was well (2016). Whether the healing of the child was coincidental or it was through the faith action performed, this is left to doubt. Ndhlela focus group’s suggestion might best

answer this question – which MCZ is at a point of realization because healing ministry has always been part of its mission. As such, it must take it as its unique theological designation.

8.2.4 Sociocultural factors that are influencing healing ministry in the MEM Societies of the MCZ

The findings from the three societies suggest that healing ministry in the societies is influenced by some external forces. Four external forces were generally agreed upon, namely, African Traditional healers, new Pentecostal churches, African Initiated Churches exacerbated by the general socioeconomic and political challenges in Zimbabwe. Epworth society steward Nota confessed that there is a sizeable number of congregants who seek healing from traditional healers and AICs. At Mbare society, some members actually transfer their faith to AICs. According to Mandizha and Viyazhi, neither AICs nor ATR has an impact at their society. However, the stewards confirmed that a bigger number of their members are visiting the newer Pentecostal Churches, with others either practicing dual membership or transferring their faith. Mbare society Mupakwachena argues that those members who have been visited as backsliders confessed that ‘if a person is ill, he/she goes to the hospital and after treatment and recovery comes back home’. Hospital is not home neither is home a hospital (2016). For Mupakwachena, MCZ is home and when people want healing, they can seek it anywhere outside the church but they will be cognisant to return to MCZ (the home). Chavhunduka affirmed the argument by stressing that the traditional healer is not as traditional as perceived. He argued that “traditional” healers are divided into different types, specialized according to their talents and calling. They are called to function in African communities as rain makers, detecting witches and criminals, “doctoring” armies, negotiating with ancestors, and using herbs and surgical procedures to cure and mend the body”.

Chipere and Pasipamire confessed that “one member actually closed the gate for them not to visit the family again because they had transferred theirs faith to UFIC” (2016). The reason for visiting other healers was neatly put forward by Paradza who maintained that the newer Pentecostal churches are in fashion and they decorate healing to match the people’s needs. This resonates with the African worldview in general which is oriented towards spiritual healing that offers something tangible. When people go to the medical practitioners, divine healers, AICs or newer Pentecostal churches, they are given something to take home be it tablets, prescriptions, charms, water or salt from AICs, handkerchiefs,

bangles and towels in new Pentecostal churches (2016). This drive for the tangible healing necessitates dual membership or syncretism. In Epworth, the issue of healing has divided the church between the protagonists and the antagonists of the ministry. The challenge is reinforced by the fact that some of the newer Pentecostal churches in Epworth are commencing healing services as early as six o'clock in the morning, making dual membership a serious challenge (Chakanya 2016).

According to Chidzambwa at Mbare society, there are some people who are known for visiting traditional healers to seek healing but they never come out in the open in fear of Methodist discipline. Some go on to give testimonies in the church ascribing worth to God, but healing would have come from traditional healers (2016). According to Bourdillion, when a person goes to a traditional healer with complaints, the healer would first find out through dialogue and divination the possible cause of the trouble. He would advise, prescribe sacrifice and rituals to be performed in seeking remedy (1989:28). It is this offering of solace to ailments that members in Epworth and Mbare sought at the traditional healers. Just like Mabelreign, and unlike Epworth, Mbare has also been impacted by newer Pentecostal churches because they claim to offer instant healing. Apart from healing, the churches associate healing with prosperity. At Mbare, some members have been identified as wearing the wristbands from either United Family International or Prophet Healing and Deliverance Ministries (Chidzambwa 2016). Chidzambwa concludes that MCZ has become a burial society more than a church. His statement makes sense if one thinks of the fears of John Wesley about Methodism that he recorded in his *Journal* of August 4, 1786 that,

I am not afraid that the people called Methodists should ever cease to exist either in Europe or America. But I am afraid, lest they should only exist as a dead sect, having the form of religion without the power. And this undoubtedly will be the case, unless they hold fast both the doctrine, spirit, and discipline with which they first set out. (Wesley 1786).

The interviews carried out suggest that there are many factors that inform healing ministry in the MEM societies. Mabelreign is affected by newer Pentecostal churches while Mbare and Epworth are mostly affected by traditional healers, AICs and newer Pentecostal churches. Although Epworth is a Methodist mission, it is sad to learn that every fifty metres in the area, one finds a traditional healer or an AIC prophet. For example, Catharine Muzhayi, one of the interviewees, stays one hundred metres from both Epworth Society and Epworth Clinic. In the valleys, the AICs are too numerous to count because of breakaways

based on power struggles. Interestingly, one AIC splinter group has their services in front of the manse (minister's house), some ten metres away at Epworth (Chakanya 2016). One of the major reasons why church members outsource healing ministry is because of the socioeconomic situation in Zimbabwe (see chapter 6). In expressing this point, Chakanya maintains that poverty has driven some Epworth members to newer Pentecostal churches where they are told to bring their parents so that they can receive prophecy together. The next move is the transfer of membership of both the traditional Methodists and their families. These people will in turn lure others to these churches, resulting in loss of membership (2016).

Although Chidzambwa confirms the same challenge affecting Mbare, he adds that healing ministry is the anchor of the church. Jesus' ministry was healing-oriented and Wesley's bestselling book *Primitive Physic* also made healing central; however, the MCZ is failing to respond effectively to the contemporary needs for healing ministry. Chidzambwa added that Zimbabwe's economy remains an obstacle to medical healing ministry in the MCZ. Those with or without money cannot access medical care. Where medical healing is sourced, it is very expensive. When healing needs arise, MCZ members think of their life first before their faith. In fact, in going to AICs, traditional healers or newer Pentecostal churches, members will be showing respect and love for their ministers, whom they know do not have the capacity to deal with their ailment (Chidzambwa 2016).

8.3 Types of Healing Ministry Methods in Methodist Church in Zimbabwe

Healing in the mainline churches must be embraced as central in their understanding and practice of Christianity. The research demonstrated that MCZ understands healing ministry is multifaceted, and that the two important issues that must be addressed are the interpretation of healing ministry and the need to inculturate the healing ministry in MCZ. The section has been divided into these respective sections.

8.3.1 Divine Healing

During the interviews, divine healing was raised by Ndhlela focus group, Mbare former Methodists, Mabelreign youth, Epworth Ruwadzano leaders, Chakanya, Chidzambwa and Muzhayi. These groups and individuals generally agreed that divine healing is God's healing power. Chidzambwa defined divine healing as God's supernaturally reaching down

to heal individuals who are in different needs of this gift. When God heals, He and He alone receives the glory and he does it in His own way, time, and for His own glory (Chakanya 2006). Ndhlela focus group maintained that the healing miracles of Jesus are utterly integral to his Messianic mission for they attest to the dawning of the new era of salvation in which illness, suffering and sinners are to be superseded by health, peace and righteousness (2016). In spite of the understanding of divine healing by these persons, the subject did not receive much attention. Furthermore, none of them mentioned any biblical reference to demonstrate that this kind of healing is only sanctioned by God whether one has faith or not. Chidzambwa argued that “divine healing is different from faith healing that calls for one’s initiative to be expressed before healing can be accessed” (2016). Although divine healing occurs in the MCZ, however, the vocabulary is not common. One member from Mbare former Methodists in a focus group argued that in the MCZ, the sick people who are prayed for and the one praying have no faith in their actions. If by any chance the person being prayed for gets well, some MCZ members begin to question the power of the healer with suspicion (2016).

According to Ndhlela Focus group, “divine healing demonstrates God’s power to the church and to his people” (2016). Chipere and Pasipamire add that “MCZ needs to move from interceding prayers where one person mediates for the whole congregation and allow people to reach God with their personal prayers. In the MCZ vocabulary, this type of prayer is derogatively called ‘mass prayer’” (2016). Chidzambwa laments that “this is one of the worst traditions that MCZ will live to regret because there are many ‘competitors’ in the religious space in Zimbabwe coming with different forms of worship that are attracting even the MCZ members” (2016). MCZ members in MEM are torn between their faith in MCZ and the divine healing of God whose theology is not well tackled. Many MCZ members continue to grapple with the question why they should suffer pain when Christ has already carried the pains and sorrows? Unfortunately, MCZ does not have readily available answers and this results in lapsing and dual membership.

8.3.2 Faith Healing

The findings of this research demonstrate that faith healing is more embraced among AIC, Newer Pentecostal Churches and in ATR. The prophets’ healing methods are similar to those of the traditional healers / *n’angas* because they specialize in exorcism and the extraction of pathologic objects from the clients (Chitando and Klagba 2013:14; Shoko

2007, 2015). In addition, “the traditional prophet also prescribes solutions such as the mixture of egg and salty water, egg and milk or salt and Coca-Cola. Healing is also done using the staff and stones among other things” (Chitando and Klagba 2013:14). In AICs, people are also given blessed water with some medicated prayers known as *mvura yemuteuro*. The prayers are supposed to give the water medically curative powers. The water should have been taken at a waterfall for those who have access to running water, while in the urban areas even the tap water is accepted (Gunda 2011:146). Salt is used to unmask evil spirits or in preventing the evil attacks on individuals (see also 2 Kings 2:19). Diseases, misfortunes, and other mishaps are understood to be the result of the works of the evil spirits. In order to cleanse people from these spirits, exorcism plays a central role. If the spirits are not exorcized, the individual cannot prosper, as such, healing is associated with prosperity in AICs. According to Leopold and Jensen, AICs are concerned with healing (2005:355). Leopold and Jensen cite one of the leaders of the Twelve Apostles Church saying “we distort our subject if we just think of Christian healing in terms of special faith healing... we are here to heal... this is not a church, it is hospital” (2005:355). Pentecostal churches use the Bible, handkerchiefs, olive oils, and wristbands, among others, as artefacts of healing. At times the sick people are told to take the elements from home and dip them in the holy water and drink, cook or bath in it (Gunda 2011:147). When Methodist members or their relatives visit these healers, they are attracted by such relics, and thereby either visit these churches or practice dual membership.

According to Maddocks, healing can be accessed through anointing with oil or laying on of hands. Laying on of hands has two levels of significance; one that is theological and one that is psychological. Theologically, it is the act of adoption. A rabbi adopted a pupil for the next course of study by laying on his hands. When used for healing, the laying on of hands adopts, drawing the sufferer more closely into the body of Christ so that the health of Jesus Christ maybe received by the sufferers. Psychologically, it is an expression of love in touch. The laying on of hands accompanied by the prayers of the church is regarded as a spiritual ministry of Great Power (1981:118). For Atkinson (2012:1), there are occasions when prayer with the laying on of hands can result in the redetection of physical, emotional or even spiritual symptoms of disease. Chakanya and Paradza concurred with Maddocks and Atkinson and concluded that this is one of the reasons ministers lay hands on the members during prayers (see also Masvanhise and Sankey 1989).

Most of the leaders interviewed confirmed that faith healing is proving to be one of the major challenges in the MCZ, with members demanding it by visiting other healers and remaining Methodists. However, Booth bemoans that some of the so-called healers have sought to exploit sick people's natural desires to be well by using miracle stories in the advertising of their services and healing missions, thereby making the whole process detrimental to the sick people (1988:5). Fund once argued that the number one means of evangelism today to people coming to faith in Jesus Christ is probably faith healing. It does not typically happen through persons being healed and then coming to faith; rather the preaching of healing and deliverance seems to create a climate that awakens faith (1989:1; Echema 2006:29; Mucherera 2001; Oosthuizen 1986; Sundkler 1961; Daneel 1970). If the Christian church is to deal effectively with the socio-economic environment in Africa in the twenty-first century, then healing must be part of the mission (Leopold and Jensen 2005:355). Healing has been divided into faith healing done by prophets and AICs whereas the mainline churches give priority to healthcare through hospitals (:355; Baeta 1962). What is somehow unfortunate is that MCZ neither has a well-defined theology on healing ministry, nor owns a hospital, and this has weakened its member's confidence in the MCZ healing ministry.

8.3.3 Medical Healing

In 2002, MCZ Conference received a proposal to expand Epworth Clinic. It was also reported that the plans had been submitted to the Ministry of Health and Child Welfare, and the ministry advised the MCZ to construct a district hospital rather than to expand the clinic (MCZ Minutes of Conference 2002:18). However, not much action was taken in an attempt to build the hospital (Chakanya 2016). In 2016, the MCZ Conference noted with concern the cost of medical care had gone beyond the financial reach of ordinary Zimbabweans. The report from the Standing Committee stated that the church's health scheme, Public Service Medical Aid Scheme, was no longer accepted by the government hospitals, private doctors and most pharmaceuticals. Coupled with this was the monthly bill for the medical aid which was exorbitant, amounting to USD 26, 364.00 (MCZ Minutes of Conference 2016:24). The conference agreed to switch to First Mutual Medical Aid Scheme where the bill was USD 17, 633.00 to cater for 286 ministers, active, students and supernumerary, 4 evangelists and 35 ministers' widows (MCZ Minutes of Conference 2016:24). The action by the MCZ Conference was concluded by Ndhlela focus group. In their contribution, MCZ does not

care for its members, given that they are left in the healing ministry of the church (2016). Paradza thinks that “MCZ has since drifted from its mandate of identifying with the less privileged of the society” (2016). These conclusions emanate from the points raised by Echema that people with any form of illness come to the church to seek healing (2006:26), unfortunately MCZ is found wanting on this inculturative healing theology. Those with chronic diseases like cancer and HIV and AIDS also present themselves for healing before the minister, and yet the clergy will not have any solution to the contemporary healthcare challenges.

MCZ inherited from Methodist Church Britain, among other things, a Service Book. The liturgy for an office for the dedication of a hospital clearly states that

... this building, which by the favour of God and the labour of man has been completed, is a symbol of that care for the sick and the suffering which was presumably exemplified by our Lord Jesus ... the service of comfort and healing for which the building is to provide ... O blessed Lord, our heavenly Father, who has power over life and death over health and sickness, grant wisdom and gentleness to all thy servants, all physicians and surgeons, nurses and watchers by the sick, that always, bearing their presence with them they may not only heal but bless and shine as lamps of hope in the darkness hour or distress and fear... (Methodist Church Britain 1965:165-69).

Unfortunately, this service was never used by MCZ since no such building was constructed. Gundani concludes that “disease was traditionally understood both in physical and spiritual terms, hence any successful cure would have dealt with both aspects of disease and this is why missionary medical centres failed to uproot traditional divine healers” (2001:5). Kaunda and Phiri maintain that “it is not possible to disuse health and healing in African Christianity without considering the traditional conception of health and healing because in African society, the search for health and healing is deeply entranced in religious beliefs” (2016:1148). The MCZ members from the three societies expressed concern over the MCZ’s reluctance to identify with the less privileged in their healing ministry theology. According to Kaunda and Phiri, health and healing in African has to do with the growth in social ordering, equal political participation, fair economic access and religious inclusion (2016:1150). In view of this, it could be argued that the healing ministry in MCZ does not meet Wesley’s standard of wholeness of health and wellbeing.

8.3.4 Sacramental Healing

MCZ celebrates two sacraments, namely, baptism and the Lord's Supper (MCZ *Deed of Church Order and Standing Orders* 2007:4). The celebration of the Lord's Supper is thought to provide a special opportunity for the healing of relationships and to prevent illness (Paradza 2016). Christians are encouraged to examine themselves so that they partake in the celebration of their fellowship with each other and with Christ (Chakanya 2016). Part of the Holy Communion service of the global Methodist Church reads, "...as we most humbly beseech thee ... O Lord comfort all them who in this transitory life and who are in the trouble, sorrow, need, sickness or any other adversities ..." (Methodist Church Service Book 1992:B49). Holy Communion in the MCZ is the centre of life and witness of the church. MCZ, Holy Communion liturgy is also present in the confessional prayers (see also MCZ Shona Hymn Book 2009:19, 25). The liturgy asserts that some sicknesses are caused by sin and as such, private confession before partaking of the communion is encouraged because in this way, the sick are healed (:31). Holy Communion is a sacrament of healing because it was instituted by the Lord Jesus. "The food he gives to Christians in the sacrament is his own divine life in the form of bread and wine which preserve their bodies and souls into eternal life" (Maddocks 1981:157). Maddocks adds that there is nothing that can add to or subtract one iota from the grace of the sacrament and its efficacy for the health of the total personality of the recipient if it is received with a lively faith (:157).

Although the Sacrament of Holy Communion in the MCZ is regarded by some as the medicine of both the spirit and the ailing Christians (Paradza 2016), it is, however, possible that some would go to the Church on a sacramental Sunday and spend other Sundays in other churches seeking healing. Gort *et al* cautions that it is easy for mainline churches to have dual membership of syncretistic tendencies. Gort *et al* argues that,

The possibility would be to have mainstream churches organize a dual ministry consisting of present ministry of the Word and Sacrament alongside healing. The former would take care of the issues concerning social justice among other things while the latter would take care of the suffering individuals (1989:120).

In view of the argument of these scholars, healing ministry should be at the centre of the mainline churches.

8.3.5 Healing through Pastoral Care and Counselling in the MCZ

Pastoral visitation forms the greater part of the MCZ ministers' pastoral responsibility (see Job Description for MCZ Circuit Superintendents 2016). Pastoral care and counselling in the MCZ traces from John Wesley who introduced Class Meetings as a platform where members felt to be part of the family of God. He records that on February, 8 in the afternoon I visited many of the sick (Wesley 1753:135). Wesley's passion for the poor society developed from the Holy Club who spent their time visiting the sick and the imprisoned (Heitzenrater 2013: 58). The reason for pastoral visitation is to give the sick an assurance that God loves them. Visitations became the heart of Methodism through Class Meetings which was a means of grace (Paradza 2016). Wesley argued that,

The works of mercy are obligatory for Christians, even if they are not in the mood for them. The hungry need feeding, even if we are not in the mood. The naked need to be clothed, whether or not it is convenient for us. The sick need help, whether or not we are feeling up to it. Those in prison need to be visited, whether or not we feel we have anything to offer those (1742).

Wesley also emphasised the need for pastoral visitation as he records in his *Journal*:

On Thursday, May 7, I reminded the United Society that many of our brethren and sisters had not needful food; many were destitute of convenient clothing; many were out of business, and that without their own fault; and many sick and ready to perish: that I had done what in me lay to feed the hungry, to clothe the naked, to employ the poor, and to visit the sick; but was not, alone, sufficient for these things; and therefore desired all whose hearts were as my heart: to bring what clothes each could spare to be distributed among those that wanted most, to give weekly a penny, or what they could afford, for the relief of the poor and sick. ... Twelve persons are appointed to inspect to visit and provide things needful for the sick. Each of these is to visit all the sick within his/her district every other day and to meet on Tuesday evening, to give an account of what s/he has done and consult what can be done further (Wesley 1741:52).

The office of the visitor was formalized for all societies connected with the Wesley brothers at the first Annual Conference in 1744. Those holding the office were charged with visiting the sick members in the area three times weekly to enquire as to the state of the soul and their bodies and to offer or procure advice for them in both regards (Maddox 2008:18).

Pastoral visitation remains important in the MCZ today with the primary duties of the Class leaders being visiting the sick and reporting to the minister (Chidzambwa 2016; see also MCZ Class Book 2014:4). In the Ruwadzano/Manyano, the visitation programme is also

important, with every Tuesday being dedicated to visiting the sick and giving them moral, spiritual and psychological support and where possible, medical support plus groceries (Ruwadzano leaders of MEM 2016). The RM leaders also confirm that every Thursday morning is set aside to visit every member of the organization by *vajekeresi* to check whether there are any reports of illness. The reports are forwarded to the organization thereby forming the basis of Tuesday visits (RM leaders 2016). The Superintendents of MEM also confirm that pastoral visitation has two aspects of care and counselling. The care is given to the ill while counselling is given to all who seek it from the minister. They agree that a day is set aside for hospital visits to care for the sick members and their relatives. Although hospital visitors are many ranging from relatives, workmates, college mates, church mates and peers, the visit of a minister is unique because when people are sick, they need a sense of the presence of the deity that is expressed by the presence of the clergy (Mujinga 2012:69).

In the context of African tradition, sickness is not only a physical disharmony, but also it has a spiritual, religious, medical and socio-ethical dimension (Paradza, 2016; see also Lartey et al (1994:16). The mainline churches, MCZ included, would acknowledge the value of the healing pastorate, however, not much actions is taken. Gort *et al* raises the same point especially as they argue “that mainline churches prefer to leave healing to prophets and traditional healers. This is not fantastic as it sounds, for it is precisely happening in the Sub-Saharan Africa. It would imply that mainlines churches in Africa would have recognized those healers and prophets as their equals” (1989:120). In view of this, the MCZ has to redefine its theology of healing in order to be relevant to the contemporary context.

8.3.6 Exorcism and Deliverance

Healing through exorcism is conducted through deliverance. Although the researcher disagrees with McNutt on many points, he agrees with him on the issue that exorcism cannot be separated from evil spirits, thus deliverance is necessary (1974). Deliverance is also common among Africans (Shoko 2007; Daneel 1990:220). MacNutt confirms that exorcism and deliverance is a controversial issue; however, it remains part of healing ministry in the broader sense of freeing humanity from all the evils that hinder realisation of the fullness of life 1974: 207). Most of the people who were interviewed generally agreed that in the MCZ, exorcism is unique and can be traced from the time of Jesus to the period of John Wesley in the eighteenth century England (see chapter 2). MacNutt defines exorcism as a formal

ecclesiastical prayer to free a person possessed by evil spirits while deliverance is freeing individuals through prayer (1974:208). According to Chidzambwa (2016), exorcism is the anchor of salvation while Daneel adds that it forms an integral part of the healing ministry (1990:220).

According to Mucherera, exorcism alone, which does not involve the course of justice, is not enough. It only resolves the *ngozi* (avenging spirit) to transfer from one person to another within the internal and external family system but does not stop until the avenging spirit's justice that seeks with the murderer has been dealt with (2001:137; Leonard 2009:182). In the event that sickness is caused by some avenging spirits, the pastor, it is claimed, should mediate between the families of the deceased and the murderer to facilitate the payment of restitution as a way of closing the reconciliation process. At the end of the mediation process, the pastor should address the *ngozi* spirit and exorcise it by commanding it to leave the murderer since they confessed accountability, paid restitution and ask for forgiveness; and families share a reconciliation meal (2001:137). It is probably against this background that Daneel argues that faith healing represents a more dramatic act of spirit expulsion. However, instead of praying to God, the priest, prophet or healer, acting as exorcist, commands the spirit invading the afflicted person to depart. Thus the ritual is a symbolic manifestation of God's power over possessing spirits (1990:220).

Mucherera's way of dealing with exorcism led the RM Thursday leader of Epworth, Mudzamiri, to conclude that all efforts are done to make sure that the service is lukewarm. This is an effort to not allow any demon manifestation because once this happens, it is regarded as a serious crime with the superintendent (2016). The Mudzamiri further state that when a demon manifests, it needs someone who is spiritually strong. One of the major challenges is that other Manyano members will leave the leaders to exorcise the demon alone (2016). This point is supported by MacNutt who claims that deliverance should be ministered with caution and only if in the prayer you judge that demonic activity really is present and that the Lord wants you to pray for this person at this time (1974:218).

Mudzamiri and Molife RM leaders of Epworth argued in an interview that, "MCZ generally does not care about those people who manifest demons. These people are considered as outcasts of the society and of the church (2016). It is probably because of this challenge that some of them will seek spiritual healing from any healing institution, be it ATR, AIC or newer Pentecostal Churches (2016). The same sentiments were expressed by Gonye and

Govhati, the Mbare RM chairpersons, who argued that during the Manyano programmes, no one is allowed to request for personally related prayers. Prayers are offered for general problems like families and socioeconomic situations in a bid to avoid manifestation of demons because once this happens, the leaders have to answer not only to the superintendent but also to the Leaders Meeting (2016). At Mabelreign, the women leaders expressed that “exorcism is not for everyone including ministers but those who are labelled ‘healers’ are the ones whose ministry is accepted by the congregants” (2016). In the same vein, the Jabangwe group of Mbare argued that the casting out of demons is the only way for the church to be relevant. It increases numerical growth, boasts financial resources for the mission, and the church becomes a “one stop shop” where preaching is not divorced from healing ministry (2016). “Many priests know that exorcism is not a mere repetition of a given formula but rather demands purity of life and a determined effort towards sanctity on the part of the exorcist” (Mwandayi 2011:256).

As argued earlier, exorcism is included in the mission of the church because it delivers people from life denying forces. Deliverance can be learned or it can be a skill acquired, and with experience and with the help of the Holy Spirit, it can become a valuable ministry (Mabelreign Youth Focus Group 2016). According to Wagner, the gift of deliverance is corrupted by some ministers who abuse the gift that they have received. All the individuals and focus groups at Mbare society confirmed an incident where one young man was taken to the clinic critically ill but the body temperature was normal. They claimed that “the clinic could not diagnose the ailment until the family (the mother of whom was in the Mbare privileged focus group) brought the young man who was in a state of coma sneezed after a prayer by Rev Chidzambwa and started to pray” (2016). This was the first healing miracle that Chidzambwa experience in his two years at Mbare society.

MCZ members suffer from some sense of being torn apart, influenced by dualities: two morals, two cultures, two values two systems and two worldviews (Mwandayi 2011:256). According to the Masvanhise and Sankey, demons are real and they need to be cast out (1989:56). Lartey et al further argue that as the traditional healers in Africa recognize demons for what they represent, the church in its liturgical celebrations and pastoral care and counselling should resist the temptation of identifying the reality of evil as psychological manifestations. The church is a healing community and therefore no missionary should attribute the title “faith-healer” to him/her or similar titles or allow others

to call him/her as such because Jesus is the healer – people are only channels of his healing power (1994:57).

The Missioners Manual presents some details as to how to exorcise demons. The first step is prayer commanding the devil to go. During the prayer session, there is no need to physically force against the person to push him/her into frenzy. Second, if the person does not respond positively, the person should be removed from the meeting to a solitary place. This is done because some demons are fake – they just want to receive attention. Third, counselling should be done after deliverance (see also Mwandayi 2011:256). “It is unfortunate that people who manifest with demons are not mentored” (Mandizha and Viyazhi 2016). This statement answers the claim made by Epworth RM chairwomen Mudzamairi and Molife who complained that “whenever there is a program for healing service, most people do not attend it because they are shy to manifest or to be humiliated as one with demons” (2016). “It is against this background that healing sessions are attended by regular members who are also often exorcised” (2016). Although Chidzambwa and Mupakwachena agree that “healing is not new in the MCZ”, however, Gonye and Govhati out-rightly declared it is a new phenomenon in MCZ thereby bringing conflicting statements among Mbare society leaders.

8.3.7 Music as a Source of Healing Ministry in the MCZ

Music plays a significant role in the birth and growth of Methodism. A lot of work has been written and generally scholars agree that Charles Wesley has emerged as perhaps the greatest hymn writer of all ages with 8,989 hymns, ten times the volume composed by the only other candidate (Isaac Watts) who could conceivably claim to be the world’s greatest Hymn-writer (Lloyd 2007:ii). “The Wesleyan brothers were not only the founders of Methodism, but they insisted that hymns, both words and music, should be written to stir the congregation and re-enforce its religious emotions. The Wesley’s made hymns the central feature of Methodist worship and before long many people began to admire the Methodists for their hearty and fervent singing” (2007:ii). MCZ inherited this rich tradition of music and the church uses four hymnbooks in the category of English 888 songs, Shona with 321, Ndebele 417 and Tonga 200 hymns. Most of the hymns are translated from English and MCZ emphasises singing of hymns more than contemporary choruses. During healing services, the congregations are encouraged to sing songs with healing messages (Chidzambwa 2016).

Many of Charles Wesley's hymns around healthcare issues stress, "Lord, teach me the lesson I am supposed to learn from this" (Maddox 2012). There are 19¹²⁰ songs in the MCZ Shona Hymn Book that stress dependability on God as the healer. A few examples of these songs will help express how hymns play a pivotal role in healing ministry in the MCZ. Hymn 25: 6 expresses God as the only Saviour and source of healing.

*Mununuri ndinomuda
Ndiye muyamuri wangu
Kana ndiri pakurwara,
Ndinosimbiswa naiye.*

The song is translated to mean "I love my saviour, He is my helper, when I am ill he strengthens me". Mazobere¹²¹ wrote hymn 156, theologising it in an African understanding of illness and what people go through during this dark cloud of life. In translating the song, the hymn ascribes all worth to Jesus as the only healer in hospital and in bed at home. It also exalts God's continuous healing and comforting love to those who have been sick for a very long time even with unexplained ailments. In addition, the song pleads with God to empower the care givers to be patient with the sick. Lastly, the singer opens the heart to the Lord in preparation of death.

*2. Pakurwara ndakarara.
Ndovimba nemi Jesu;
Ndigadzirirei nzira
Yokuuya kwamuri.*

*3. Hamunete kubatsira
Varwere vatambura
Nokurwara kwamakore
Nezvirewe zvizhinji.*

*4. Itaiwo kuti hama
Neshamwari dzitende;
Varege kuora mwoyo
Nokuti ndiri ndonda.*

Hymn 123 presents Jesus as the great physician who heals those who have faith in him. In addition, hymn 218 exhorts God to take care of the sick. Hymn 296 presents the story of

¹²⁰ The hymns with the theology of healing ministry in the MCZ Shona Hymn book includes hymns 25, 44, 48, 59, 156, 77, 159, 205, 218, 254, 102, 132, 152, 249, 306, 131, 296, 295 and 123.

¹²¹ R.C Mazobere was one of the Methodist Evangelists and the father to the former Bishop (now Presiding Bishop) Rev Dr Caspen Mazobere whose name was given to Epworth "rich" focus group.

Jesus being surrounded by sick people who came dejected but went home rejoicing after they were healed. The song goes on to request Jesus to demonstrate his healing power to those not feeling well for he is the all-time healer. Moreover, hymn 295:5 is a prayer to God to heal all kinds of ailments. Masuku¹²² said that hymn 306, when translated, clearly spelt out that some were gifted to be preachers, teachers, singers and some healers.

306 Vamwe makavapa zvipo 'zvo
Zvokuita basaro
Asi vamwe havambogona
Kuona tarendaro
Vamwe vanoparidza
Vamwe vachidzidzisa
Vamwe vanorapa zvirwere
Nhasi ava vaimbi.

Since the hymn was written by the former church leader, it therefore becomes obvious that in the MCZ, some were called to be healers (Paradza 2016). Hymn 183 written by Charles Wesley uses African terms like *ngozi* which refers to avenging spirits which might also lead to misfortunes and death (Shoko 2007:59). It is not clear whether the translators referred to problems or avenging spirits which are also another source of illness in Africa. The word is also used in hymns, 41, 54, 192, 198, 246, 251 and 252. In all these songs, Jesus is declared as omnipotent to overcome the evil spirits. All the interviewees concurred that hymns are what makes MCZ unique. The Mabelreign and Epworth stewards agreed that there are conflicts in the church on whether people should sing contemporary choruses or hymns only, with the Leaders' Meeting expected to make a ruling. The English Hymn 393 states that Jesus' hands were kind hands, doing good to all, healing pain and sickness, blessing children, washing tired feet and serving those who fall. Hymn 528 also by Charles Wesley exhorts something similar to this. The song says, "Leave me not alone, still support me and comfort me...raise the fallen, cheer the faint, heal the sick and lead the blind (Methodist Church Hymn Book 1989). Music in the MCZ is a panacea to every form of problem and the hymns are sung in a special way that draws people to the grace of God in order to be healed.

¹²² Masala .Baxter Masuku is a supernumerary (retired) minister in the Methodist Church in Zimbabwe. Before his call to Local Ministry (part-time), he was elected Connexional President in 1986 and 1988-1990.

8.3.8 Prayer

MCZ's theology of prayer is divided into two, namely, intercessory prayers where at every gathering, an individual prays on behalf of all others, and liturgical prayers written in the Hymnbook and Prayer Book. Although the raising of hands represents a true biblical precedent for the lifting up of holy hands in prayer to God (Psalms 63:1, 1 Timothy 2:8), MCZ is reluctant to use this method of prayer (Chakanya 2016). In the Bible, hands were outstretched in praise and intercession of petition with palms facing upwards to God. The praise of raising hands with palms facing forward, sometimes accompanied by either trembling of the hands or the shaking of the head, is discouraged in the MCZ (Chidzambwa 20016). Masvanhise and Sankey maintain that this act is practiced by some sectarian groups and in some traditional rituals and should be avoided at all costs since it could easily bring confusion in the church (1989:56). MCZ encourages that when praying for people, laying on of hands should clearly follow the biblical patterns of Mark 16:18, Acts 9:17, 19:6, and James 5:14 when praying for sick people or praying for the fullness of the Holy Spirit. In both cases, it is advised that hands are laid gently on the head or shoulders of the person being prayed for (:56). No force needs to be exerted and no shaking is necessary. Sometimes the local church has been unhappy about a particular person laying on hands because they know of some immorality or sin in this person's life. Such a person should not be allowed to bring the evangelism ministry into disrepute (56).

Local Leaders Meetings are encouraged to approve those who go to the evangelism committee to make sure that they have a clean life (Paradza 2016). Masvanhise and Sankey discourage members or even Missioners going into trance-like state, sometimes with speaking in tongues (1989:56). For them, the Holy Spirit does not behave in a similar way to the ancestral spirit possessing a person. With the Holy Spirit, the person filled is always in control as to how to behave and whether he or she speaks in tongues or not (:56). Masvanhise and Sankey further caution that the church must learn to discern between a genuine gift and a counterfeit gift. We must not imitate the way some churches practice the gifts (:56).

8.4 Possibility of Inculturating Healing Ministry at MEM Societies of the MCZ

The possibility to inculturate healing ministry in the MCZ is highly contested. Two subthemes have been identified, namely, natural healing and traditional healing. The two

subthemes will help us appreciate whether inculturating healing ministry in the MCZ is the way to go.

8.4.1 Natural Healing

The need to inculturate healing ministry in the MCZ comes from two backgrounds; the need to embrace Wesleyan theology, and the socioeconomic environment of Zimbabwe. According to Hayes, “natural healing refers to the healing of physical maladies by the body’s built-in mechanisms. It may also include the assistance of medical applications such things as herbs, medicines, poultices, body casts, therapies and surgeries” (1995:8). John Wesley strongly believed in natural healing. He records many incidents of natural healing in his *Journal*. In one of them he writes that, “...feeling myself very sick, I desired a glass of cold water, which instantly gave me ease” (Wesley 1758:144). Wesley also claim that he “ordered some brimstone to be powdered, mixed with the white of an egg, and spread on brown paper, which I applied to my side. The pain ceased in five minutes, the fever in half an hour; and from this hour I began to recover strength. The next day I was able to ride, which I continued to do every day till January 1” (Wesley 1753:151).

Although Wesley did not pronounce that healing ministry should be inculturated, from his actions, one notices some pointers to him being a champion of this theology, though the term is a relatively later development. In his *Journal*, Wesley also describes how medication was accidentally discovered and used naturally. He states that,

Some years, one walking in a grove of pines, at a time when many neighbouring towns were affected with a kind of a distemper, little gum fell upon one of the trees on the book which he was reading. This he took up and thoughtfully applied to one of those sore places, finding the pain immediately cease, he applied it to another which was also presently healed. The same remedy, he afterwards imparted to others and did not fail any that applied it and doubtless, numberless remedies have thus casually been discovered in every age and nation (Wesley 1747: iv).

Accordingly, physic was wholly found on experiment, thus healing has to be natural. The *Primitive Physic* is a product of Wesley’s experience with natural healing. It is from this background that Mandizha and Viyazhi argued that healing has to be natural. They submitted that although medicine should be naturally used, members must avoid visiting tradition healers (2016). Chidzambwa and Mupakwachena shared the same sentiments but Nota went further to argue that some church members at their societies were actually inculturating healing ministry to protect their children (*nhova*). Mupakwachena and Nota

agreed that considering the cost of living in Zimbabwe, inculturation of healing ministry will help restore some lives that have been destined to perish. They further stated that without the inculturation of healing ministry, the church remains an artificial institution (2016). Their conclusions were however challenged by the youth of the same societies who maintained that inculturating healing ministry is liable to neutralize the faith of the church. Congregants won't be able to distinguish between the traditional and natural healing, hence the two should not be used together. They conclude that MCZ should rely on divine and faith healing only (2016).

Chakanya stated that the inculturation of healing ministry is good for the church, because it makes use of natural resources created for humanity (2016). Mandizha and Viyazhi argued that the only danger of inculturation is reminding Christians of their past spiritual lifestyle (2016). The stewards also concurred with Wesley who once encouraged a neighbour to take natural medication, when he was bitten by a snake. He also prescribed him to chew and apply roots so that the poison would not hurt him (Wesley 1747: iv). On sickness, Wesley stated, drink the juice of some herbs and your sickness will come to an end (: iv). Mbare youth accused the MCZ's spiritualization of everything including healing ministry. They had a feeling that MCZ should inculturate healing ministry to avoid syncretism. When someone needs natural healing, it must be respected in order for the church to avoid dual membership or total loss of the members to other faiths (2016). Mbare youth insisted that one of the reasons why the youth are leaving MCZ is the need for healing ministry. In using natural means of healing, the church is actually doing the mandate of God because natural ways of healing are also common in the Bible.¹²³ Epworth and Mabelreign youth confessed that all the natural resources are made by God; as such, natural healing is making use of the

¹²³ "The Bible has many incidences where natural ways of healing were used. For example, an aloe vera plant has been used to heal a variety of conditions, most notably burns, wounds, skin irritations, and constipation. Aloe was also used to embalm the dead, as well as for perfume. Today, aloe is used in many ways including treating burns, sunburns, healing bruises and rashes, to moisturize skin, fight athlete's foot, and prevent scarring and stretch marks and speed up hair growth. Bitter herbs are a collective term used for lettuce, horehound, tansy, horseradish, endive and coriander seeds. Bitter herbs were mostly used for food. In fact, the people of Israel were commanded to have bitter herbs with their Passover lamb. Today, they can be used to help with urinary tract infections, kidney stones, fluid retention, achy joints and gout. Garlic has been used as both food and medicine in many cultures for thousands of years, dating back to when the Egyptian pyramids were built. Today, garlic is used to help prevent heart disease, including atherosclerosis or hardening of the arteries (plaque build-up in the arteries that can block the flow of blood and may lead to heart attack or stroke), high cholesterol, high blood pressure, and to boost the immune system. Garlic may also help protect against cancer". <https://draxe.com/the-top-14-herbs-of-the-bible/>

cosmology that God gave to humanity. If the church cannot help people, then they should refer them to the relevant healers, including hospitals, clinics and hospices, but not to other spiritual healers since this compromises the church's faith. Those with the gifts of healing must be allowed to practice it within the church openly and the church worship must have a component of healing ministry.

Natural healing most specifically refers to the use of herbs. Larkin defines a herb "as a plant whose flowers, leaves, or roots contain chemicals that have a potent effect on the human body for healing. Herbal gardens are described as herbal medicines, nutraceuticals, botanicals, herbal remedies – but the bottom line is that God provided certain plants with chemicals in them that can act in the human body to promote healing under His direction" (2004:8). Tapping from this understanding of herbs as an essential natural method of healing, Mbare society has an herbal garden. During the interviews at Mbare society, it was evident that there were mixed feeling on this garden. The Mandinyenya focus group felt that the herbal gardens allow the traditional healers to masquerade as herbalists (2016). Ruwadzano leaders Gonye and Govhati from the same society felt that herbal gardens are God's way of reaching out to the health needs of his people. However, they further caution that the church should not rely on herbs but on God for healing because the history of the herbs is common through their use by traditional healers. In contrast, they even cited how John Wesley used herbs to heal himself and his horse (Maddox 2012). The former Methodists of the same society of Mbare conceded to Wesley's theology of natural healing and that of the MCZ, however, they complained that although the church has an herbal garden, people were never taught to differentiate its herbs from those of traditional healers, thereby creating a gap for syncretism (2016). The group concluded by encouraging the MCZ to revisit Wesley's theology on healing. The Jabangwe group strongly believed that inculturation of healing ministry is the best way to theologise healing ministry. They went further to discourage the church from relying exclusively on modern medicines because they are expensive and are not affordable to the poor.

Unlike Mbare society that possesses an herbal garden, Mabelreign society hires voluntary medical doctors in December of each year in the name of Health Day. On this given Sunday, the church services will be conducted while congregants will be consulting with medical doctors, opticians and dentists in the church premises (Paradza 2016). Healing ministry will be offered freely and the church's role will be to appreciate the voluntary medical

practitioners. Given the variances of Mbare and Mabelreign societies' approaches to healing ministry, the Ndhlela group argued that inculturation of healing ministry should be abandoned because this demeans divine healing. In the opinion of this group, herbs are more cultural than they are natural gifts from God and MCZ should revisit the Bible to come out with the right theology on natural healing.

Makuzva focus group from Mabelreign also put more weight on the health day by stating that MCZ is not a medical fraternity; as such, medical issues should be referred to medical personnel (2016). For them, herbs actually compromise faith rather than enhance it. Herbs are neither quantified nor purified, thereby making them dangerous for human consumption without the assistance of the medical practitioners. Using herbs is attempting to privatise the healing powers of God (2016). The emphasis on health day by Mabelreign focus groups is understood better especially as one appreciates that they are people from the low density area who are highly influenced by Euro-centric medicalization of healing ministry. Mabelreign youth caution that MCZ should not be dragged into syncretism in an attempt to justify natural healing. The youth also challenged MCZ to desist from glorifying some healing aids like anointing oil and discarding others like herbs. MCZ must refer every health need to the relevant institution. For example, spiritual things to the church and physical needs to the hospital. Herbs should be the last resort (2016). Besides prescribing how MCZ should guard against the herbs, the youth were not clear on their position on inculturating healing ministry.

Epworth society neither has a herbal garden nor health day but they understand healing ministry from the mission clinic that they have. Chivi group claimed that "all medication is God given but inculturating them is a challenge. If natural medicine is to be inculturated, it must have to be blended with missionary medicine. Christians must not use natural herbs openly because it leads those with weak faith to compromise their spirituality. They suggested that MCZ must have a day set aside for healing through different ways" (2016). This is a contradiction of what the other societies subscribed to. Wesley's prescription to health helps us to understand that natural medicine goes beyond herbs. Apart from medication, Wesley prescribed some daily routines as medication,

Abstaining from all high seasoned food and use of plain diet easy of drink only water if it agree with one's stomach if not good clear small beer. Do much exercises daily in the open as one can without weariness. Take supper at six or seven on the highest food. Go to bed early and rise early again for in this course, this is often half of the

cure. Above all add the rest of that old unfashionable medicine, prayers and have faith in God, 'who killeth and maketh alive who bringeth down to grave and bringeth (Wesley 1747: xii).

Wesley regarded air, food and drink, sleeping, walking, motion and rest, evacuation and retention of the mind as easy and natural methods of healing (Maddox 2007:4). Wesley was not limited to these natural remedies, he was also using pharmaceutical, emotional and spiritual treatments. When his brother Charles was ill, he suggested consultation with a physician, exercise on a wooden horse, and electrotherapy (Maddox 1994:146). Ian Cottshills, a former Methodist from Mabelreign, argued that inculturation of healing ministry does not start with medication but with taking some traditional foods (2016). His point was supported by Mr and Mrs Jack who accented the fact that people are prescribed some specific types of food and abandoned to eat some when they are sick means that food is another form of inculturated medication (2016).

8.4.2 Traditional Healing

Traditional healing has been adversely affected by western Christianity, colonialism and modernity. These triple forces have portrayed it negatively, suggesting that it belongs to the past and evil world. This assumption has led many people to readily dismiss all healing claims emanating from traditional healers. It is premised on the question, what good can come out of the traditional medicine? (Chitando and Klagba 2013:8). For Mafavuke (2017), the colonial government and early Christian missionaries despised African traditional medicine and therefore attempted for many years to discourage its use. There are a number of reasons why they suppressed traditional healing. First, they considered traditional healers as deceivers who prevented people from visiting hospitals where they could access western medicine. Second, many missionaries felt that traditional healers promoted witchcraft which missionaries regarded as the greatest stumbling block for the spread of Christianity. Third, traditional healers were accused of associating with the ancestral spirit, and the healers were seen as agents of the devil who encouraged people to engage in ancestral worship (1978). Berends' article "draws attention to the continuing popularity of African traditional healing practices, and asks whether African churches and modern medical programs can continue simply to denounce or to ignore such practices. The need for a further appraisal becomes apparent when it is shown that the purposes of these healing practices fulfil certain functions not met by modern medicine" (1993).

Paradza attributed healing ministry in the MCZ to African religio-cultural traditions. For him, “the centrality of healing in African religio-cultural heritage entails that MCZ members are already entrenched in African spirituality” (2016). In African spirituality, physical health and spiritual wholeness are not sharply distinguished as is the case in classical western thought. A physical evil may well have a spiritual cause. The battle for life is a battle against evil spirits (see also Werbter 1989:3). Chakanya argued “that there are actually some traditional healers that worship at Epworth society and this has created a rigid society in as far as the theology of healing is concerned” (2016). Mazobere group supported this point by stating “that people are actually visiting the traditional healers to seek free healing” (2016). The point was supported by Gondongwe who argued that traditional healers still play a crucial role in the MCZ (2016). The indigenous ministers duplicated on the way they dealt with witchcraft and traditional healers (Idowu 1969). The treating of illnesses and diseases in the Shona society is defined in terms of different categories. First, serious illnesses and diseases are treated by various forms involving herbal treatment, extraction of disease-causing objects, and exorcism of undesirable spirits. Second, minor ailments are cured by medical treatment. Witches cause illness by planting poison on objects on a path or any place, and contact results in people becoming sick (see also Shoko 2007:502-06). Given the fact that the areas under study are populated by Shona people, the solution to their illness are motivated by Shona African spirituality.

Epworth RM leaders also expressed the critical role of traditional healers in their society. They claim that “many people in the MCZ have some cultural problems and this is evidenced by the fact that in Epworth, it is uncommon not to find either one person who is not employed but is qualified and highly educated. This person might be a drunkard, “prostitute” or not married. This is sign of a cultural problem that can only be dealt by a traditional healer” (2016). According to Togarasei, “Africans view life holistically without” (Togarasei 2009:52). He adds that “African communities need to know what caused the illness. It is therefore uncommon that even if through the use of biomedicine, all the symptoms have disappeared, the community will approach a traditional healer or a Christian prophet to tell them the cause of the diseases and perform a fitting healing ritual” (Togarasei 2009:52). The belief in herbalists among the Shona people was well illustrated by Masaka and Makahamadze who state that;

In Zimbabwe even a Shona who lives a sophisticated western life in town, would if faced with critical illness either in himself or his family consult the diviner or

herbalist to learn whether there was something he could do to appropriate the anger of a member of his family or to discover if the illness were due to the influence of the witch (2013:134).

Muzhayi argues that the cost of living in Epworth has necessitated some members at Epworth not only to visit traditional healers but AICs, including her own shrine (2016). Mbiti sums this debate by stating that the recognition of traditional maladies is not the only way which has a bearing on African spirituality, but the traditional medicine used by diviners has an influence on the church's ministry of healing among the Africans. As such, Christian healing in Africa must try to meet the same needs that were being met in the traditional healing services. This means that the ultimate question about the cause of a sickness must be answered by churches in Africa within an African religio-cultural frame (2002). "Many of the needs met by African traditional medicine are also the same needs that can be met by proper pastoral care givers. The ministry of the church not only includes counselling, but also preaching. In this preaching, the pastor can fulfil an important aspect of healing ministry of the church and it is here that he/she can deal with the role of causative medicine" (Mbiti 2002:45).

One other effect that necessitated MCZ members to visit traditional healers has been espoused by Waite who claimed that,

The champions of western medicine took various measures against traditional medicine such as seeking to undermine its legitimacy through the mission schools, organizing their professional organizations which could censure colleagues who referred patients to traditional doctors and insulting patients who used traditional medical treatment but those who were treated by western doctors could submit certificates and letters attesting to this. Traditional medicine was also suppressed by the Witchcraft Suppression Act of 1899 which criminalized both malpractice and legitimized practices since it subdued most materials by healers under the rubric of witchcraft even though many of the charms had nothing to do with witchcraft (2000:238).

From the analysis given above, it becomes obvious that some MCZ members at Epworth and Mbare visit traditional healers in the dark of the night because this act is regarded as violating the rules of the church in general (Echema 2006:29; Mucherera 2001; Oosthuizen 1968; Sundkler 1961; Daneel 1970) and MCZ in particular (MCZ Class Book 2014).

8.5 Methodist Church in Zimbabwe's Understanding of Healing

Apart from the mixed feelings on the definition of inculturation of healing ministry among the leaders of MEM, it is a worth pursuing the understanding of this phenomenon from the MCZ leadership in general. The Presiding Bishop's address to the Ministerial Session¹²⁴ of Conference reiterated that "while healing and deliverance remains central in MCZ, clergy must approach it theologically because some congregants were complaining about the extremes of healing practices related to this ministry" (Ndhlumbi 2014:11). Ndhlumbi further reminded the ministers to observe the MCZ traditions and practices when conducting healing and deliverance ministry sessions (:12). Although Ndhlumbi did not explain what he referred to as the Methodist traditions and practices, the Conference endorsed this statement. First, the conference resolved that there was a need to go back to the original healing and deliverance practiced by Methodists since the issue was dividing the church. Second, the Conference endorsed that there was a need to harness the situation in its infancy because the issue is tantamount to dividing circuits. Third, the Conference cautioned ministers not to attack each other based on this theological issue. Conference also highlighted an incident in Masvingo District where the District Bishop and the Superintendent clashed in front of the congregants over healing and deliverance issue" (2014:12). The conference concluded by setting up a committee that was going to research and present a paper on healing ministry at a Ministers' Retreat¹²⁵ (MCZ Minutes of Conference 2015:8). The main argument that was supposed to be raised by the presenters was to what extent healing ministry was part of the church.

Ndhlumbi's statement, "Methodist tradition and practices", presents a number of challenges. First, the term Methodist is ambiguous because there are many Methodists globally with different traditions and practices. Second, in the preceding chapters, it has become clear that MCZ does not have a position on healing ministry, meaning that discussing about traditions and practices is misinterpreting the ethos, polity and theology of MCZ. *The Deed of Church Order and Standing Orders* is silent on this subject. Some of the

¹²⁴ Ministerial Session refers to the session that is attended by ministers only at the District Synod or Conference (MCZ *Deed of Church Order and Standing Orders* 2007: 27, item 101). Some of its responsibilities include dealing with character, discipline, competence and pastoral fidelity of MCZ ministers (:15. 26 a-d).

¹²⁵ The ministers who were appointed were Revd Dr Simon Madhiba, Bishop Tongayi Matamba, Rev Johnson Makoti and Munetsi Hokonya. It was unfortunate that these ministers addressed the issues of theology generally and did not venture into the controversial debate of healing ministry in the MCZ.

clerics and lay people who were interviewed argued that it is not proper to document or prescribe the issues of faith, that's why the policy book of the MCZ did not legislate healing ministry. Third, when the missionaries transported the gospel to Zimbabwe, they did not transplant it to transfuse with African culture in order to produce hybrid Christianity. It is only during the process of inculturation that the marriage of the gospel and culture is being implemented. This marriage in this research is what we are calling missio-cultural. Fourth, the practice and tradition of healing ministry in the MCZ can be understood from the *Missioners*¹²⁶ *Training Manual*, which states in part that:

The missionary should firstly, pray for healing to take place in the name of Jesus Christ. Secondly, the prayer for people should be as personal and as specific as possible. Thirdly, the healers must pray for themselves in groups before the beginning of the service of praying for others. Fourthly, during the healing process missionary must ask the person's name, his/her problem, fifthly, one or more people of the team members should pray for the sick person using the name of the person and laying hands on the head or shoulder of the person. If that pain is in a specific part of the body, e.g. back, then it may be appropriate to place a hand there but obviously not in any intimate part of the body. Great care must be exercised not to cause any offence or embarrassment and lastly after praying for person needs, he/she must be helped to stand. The next step to take is to enquire whether the individual has already experienced any specific answer to prayer. If yes, they should be given an opportunity to testify before the end of the meeting. If no, the member should be encouraged to trust God for a positive answer because specific prayers in faith is giving thanks to God (Masvanhise and Sankey 1989:46).

Although the book is detailed on the expected procedure by MCZ on the healing ministry, Ndhumbi's assertion cannot be justified by these prescriptions because the *Missioners Manual* is only meant for the few people being training in evangelism programmes and it was only applicable after an 8-day evangelism programme between 1989-1991 (see also Masvanhise and Sankey 1989:5). That being as it may, it can be concluded that Ndhumbi's statement still obliterates the major point he was making, thereby making his address ambiguous.

In his last address to the Ministerial Session as the Presiding Bishop, Ndhumbi changed his language on this subject, emphasising that healing and deliverance sessions should include components of pastoral care and counselling. He also reiterated that there was a need to come up with a holistic approach in healing (Ndhumbi 2015:4). In response to the Presiding

¹²⁶ *Missioners* in the MCZ refers to lay people who are trained in Evangelism programmes so that they will in turn teach others.

Bishop's address, the ministers complained that the relationship among the ministers is getting worse because of the subject of healing. They further argued that the other intriguing challenge with the subject is that some members have special preferences on "some ministers", and as such whenever there are crusades, they form long queues on one minister while others are left without anyone (MCZ Minutes of Conference 2015:4). The subject was referred to the Ministers' Retreat the following year, which never met because of some unspecified reasons.

The last point that is more worrisome is that in 2016, the new Presiding Bishop Rev Dr Zwana, in his address to both the Ministerial Session and to the Representative Session¹²⁷ of Conference, never mentioned anything about the subject of healing ministry. Worse still, the Minutes of Conference of 2016 are also quiet on this subject of healing ministry and about HIV and AIDS (Mujinga and Moyo 2016:52). For three consecutive years Rev Ndhumbi has addressed the issue of healing ministry but he has never cited the *Missioners Training Manual* as an official document that contains the MCZ theology of healing, nor a book on healing by MacNutt (1974). Contrastingly, Zwana dropped anything to do with missional healing and concentrated on medical healing with special reference to the medical aid scheme of ministers and the ministers' widows, thereby side-lining the healing needs of the church members, not only in the researched societies but MCZ in general, both the privileged and the less privileged (see also MCZ Minutes of Conference 2016:24). One might want to attribute Zwana's silence on this subject to the MCZ 2015 report by the Mission Director Rev Dr Gondongwe who claimed that, "We thank God because cases of ministers and lay leaders who use oil, handkerchiefs and other symbolic commodities are on the decline. We encourage both the ministers and the laity to exercise their ministry within the confines of Methodist beliefs and practices (MCZ Minutes of Conference 2015:29). There is no evidence that other reports refer to his claims, thereby pushing the researcher to conclude that Gondongwe has fallen in the hands of Ndhumbi's uncoordinated theology of healing ministry, which is dangerous from the church leadership. In the absence of a clear definition of healing ministry by the church leaders, it therefore compels us to analyse the proposed definition of healing ministry from the voices of those from the underside.

¹²⁷ Representative Session of Conference refers to the session of conference attended by both the clergy and the laity (MCZ *Deed of Church Order and Standing Orders* Section 10:101 (terms defined), p. 27.

8.6 Challenges Posed by Variances in Understanding Healing Ministry in MEM

Healing ministry has brought a number of challenges to MEM. First, the ministry is associated with materialism and most members want to identify with ministers who practice it. This challenge has also necessitated the stationing (deployment) of ministers to be biased towards either anti- and pro-healing ministry (Paradza 2016). Second, the understanding of MCZ theology of healing has been made contested terrain where the church has to brace for change in view of the changing times (Chidzambwa 2016). Third, MCZ needs to identify among its ministers their gifts so that those who have been gifted in healing will practice it. Although Epworth has a clinic close to the church, church members pay for medical services in spite of the fact that about 80 percent of the personnel are Methodists (Chakanya 2016). All the interviewed participants confirmed that they are not aware of any locally produced literature on healing ministry in the MCZ. This has created despondence among church members toward healing ministry (Chipere and Pasipamire 2016). Mudzamiri and Molife claim that many Methodist members have cultural problems. This is evidenced by the restlessness of the church members in search of healing from AIC, ATR or newer Pentecostal Churches. Healing is mostly sought during the night and during the week. The few hours MCZ members stay in the church during worship time does not bring much difference to their pressing healing needs. Epworth RM leaders made the challenges more complex by claiming that although members visit different faiths for healing, they never want to identify with them permanently but prefer hybrid Christianity. Some incidences have been witnessed where ministers clash over deceased members of the church (2016).

Makuzva focus group maintained that although there are numerous challenges, healing ministry redirects people to their rightful theology. MCZ does not need to follow the current microwave type of fast theology of healing ministry but to redefine itself in view of its roots. Mr and Mrs Jack further argued that MCZ takes for granted the divine healing that God is demonstrating in the church. They stated that although MCZ members in MEM societies feel they are not satisfied by healing ministry in the church, in actual sense it is God who heals and not people. The biggest challenges is that people confuse divine healing and the acts of individuals who are self-acclaimed prophets who present themselves as orators in order to lure people to them (2016).

8.7 Conclusion

The chapter has discussed the understanding of healing ministry by both the leaders and the ordinary members of the MCZ in MEM societies. The research concluded that the definition of healing ministry in these societies is influenced by their sociocultural and economic environment. Divine healing, faith healing, medical healing, sacramental healing, pastoral care and counselling, and exorcism and deliverance were discussed as the key themes that arose from the interviews. In addition, Methodist music and prayer were concluded to be some of the key facets of MCZ theology on healing ministry. Moreover, the possibilities of inculturating healing ministry through natural healing and traditional healing were also explored. The research methods used have also helped in coming out with a theology that can be used by each of the societies in their healing ministry. Since the three societies are all in Harare there are three approaches that they can be used to inculturate healing ministry. First, MCZ should teach its members the basic theology of medicine, inculturation and medicalisation of healing ministry. Second, given that Zimbabwe continues to go down economically, the societies need to embark on herbal gardens as a way of having natural medicine. Third, spiritual and faith healing also need to be taught on all the society so that they will be in a position to differentiate exorcism from deliverance and how prayer and faith solve these spiritual problems. The challenges that posed variances in the understanding of healing ministry in the MCZ were discussed and the next chapter will address some of the missing links. The conclusions from this chapter are leading to the general conclusion of this project. The next chapter will give a summary of the whole project and unveil the new knowledge that has been contributed by the research.

CHAPTER NINE

GENERAL CONCLUSION

9.1 General Conclusion and Findings

The missio-cultural examination of the healing ministry within MCZ societies of MEM have realized a gap that is a potential danger to the further split of MCZ. The varied perspectives among the clergy and the laity on healing ministry in the MCZ have led to this missio-cultural research. In this chapter, the task was to analyse the extent to which MCZ is responding to the healing needs of its members. The chapter also identifies areas for further research.

The missio-cultural research concluded that healing ministry has always been the call of the church. Jesus' mission on healing ministry was anchored on healing ministry and he handed it over to the early church. In the development of Methodism, health and healing were central to John Wesley's theology. . The socioeconomic environment of his time, his mother's health challenges and his own personal health challenges contributed to this passion for health and healing. Wesley introduced inculturation in healing ministry, especially as he aided prayer and natural means of healing. For him, healing was wholesome because it focuses on the whole being. In Wesley's theology, salvation could not be defined independent of healing and wholeness. Wesley's *Primitive Physic* prescribed different prescriptions for healthcare and a number of them were through natural means. This action seems to suggest that Wesley was the champion of inculturating healing ministry. However, MCZ is grappling following the Wesleyan theology of healing probably because the Methodism that was transported and transported to Zimbabwe was crowned in the Eurocentric culture thereby causing the locals to receive it with suspicion.

The missionaries did not understood the healing ministry of the locals which was grounded in African spirituality. They wanted these African healing models to be suppressed by western modes of healing but the results were missio-cultural confrontations. This missio-cultural confrontation resulted in reaction by some local Methodist members, thereby forming a hybrid theology of healing. The hybrid AICs that came out of the need to inculturate healing ministry are Guta Ra Jehovah, African Apostolic Church, Bethsaida Apostolic Church, Voice of God Apostolic Church, Harvest Apostolic Ministries and Revival Fires Apostolic Church. It is also important to note that the theological

inconsistencies on healing ministry that were transported, transplanted and transmitted to Africa by the missionaries created a schizophrenic and contradictory theological attitude towards healing within the African context that resulted in the MCZ functioning like a potted plant (see Smith 1984). In an attempt to be relevant in the socio-economically crippled Zimbabwe, MCZ still grapples with defining healing ministry. In this dilemma, the church is somehow responding to the external environment as argued earlier. This scenario has resulted in some MCZ clergy changing the traditional Methodist title of reverend, taking on the appealing ones of apostles and prophets in order to fit in the twenty-first century ecclesiastical space characterized by charismatic churches that claim healing to be central to their mission. The same challenge affected the Caribbean Church as Hewitt (2012) and Smith (1984) succinctly espoused. According to Smith, the Caribbean Church failed to be the church in the context in which it was planted (1984). Since the research made use of the missio-cultural conceptual framework of Hewitt, it becomes evident that the same scenario had the same roped MCZ. It also makes sense given that Zimbabwe, just like Jamaica, went through the similar process of church planting and the quest for inculturating the gospel to be relevant in the local context (see also Smith 1984 ; Hewitt 2012).

Pastorally, the research unveils that healing ministry in the Methodist Church in general was introduced by John Wesley through the office of the “visitor of the sick” which was formalized in all the societies with the aim to visit the sick (Maddox 2008:18). “At the 1744 first Annual Methodist Conference, those holding the office of ‘visitor of the sick’ were charged to visit members in their area three times a week, to inquire the state of their soul and their bodies and to offer them or procure advice for them in both regards” (:18). This office still has a very important role in the healing ministry in the MCZ as it is defined in the MCZ Class Book. Although Wesley had passion for healing ministry, however, the MCZ that inherited this Wesleyan’s tradition are taking a lukewarm stance to this ministry. During Wesley’s time, the lay preachers who assisted him were instructed to visit the sick and advise on the medication to take depending on the ailment. This is unlike in the MCZ where healing has been side-lined to the individual few ministers and few church members (see also MCZ Minutes of Conference 2011 and 2014).

The scenario cited above have led MCZ to push its frontiers towards the negative developments of division among its clergy members and the laity based on the gift of healing. Ministers are competing and at times there are confrontations emanating from

healing gifts. In addition, it is evident that healing ministry has become a source of living for some ministers in the MCZ. The major reason being the attachment of the members to the individual clergy. Given the laxity of the MCZ on this theology; members are demanding this commodity from a few individuals who in turn become overwhelmed and cause more damage to the congregants' faith. The research argues that if MCZ has to be a relevant church rooted in the Wesleyan theology of healing, she needs to take healing ministry as the pinnacle of its mission. Apart from the challenges of MCZ cited above, the socioeconomic challenges of HIV and AIDS have created a theological need that compelled MCZ to engage in this ministry but with half the heart. However, because of the same challenges, MCZ disengaged from its pastoral ministry to people with HIV and AIDS.

MCZ members felt that healing ministry should not be a mission confined to ministers only but to all those who are gifted whether they are MCZ lay members. Although some interviews felt that those who pray for the sick people should address the needs so that the challenge can be solved once and for all, this statement is dangerous because those who practice healing end up deifying themselves. Healing is God's means of grace to his people. The interviewed members also suggested that the church should introduce a healing school through a channel where people would be prayed for every time. In addition, they called for the church to introduce cultural healing because natural resources belong to God. The congregation also noted that the youth are continuously migrating to the newer charismatic churches which is a future challenge for MCZ. In order to inculturate healing ministry, the missio-cultural research noted that MCZ needs to introduce a Health Day whereby the mission and vocation of the church will be shared as far as inculturating healing ministry. In the context of the ongoing socioeconomic challenges, the introduction of herbal gardens helps come up with the enculturated healing ministry which Wesley advocated for (see chapter 2).

Academically, the research noted that the lack of locally available literature on healing ministry by MCZ has led the members into a schizophrenic situation where they oscillate between Methodism and other faiths in search of healing ministry. In a socioeconomically challenged country like Zimbabwe, healing is inevitable. However, the inculturative call seems to be the challenge in the MCZ. The literature that was consulted on healing ministry by John Wesley, AIC, and Newer Pentecostal demonstrates that no church can survive without healing ministry. However, the move taken by missionaries to establish medical

institutions for the MCZ in particular did not yield results but missio-cultural conflicts. The need to inculturate healing ministry in the MCZ remains central if the church is to be relevant in its mission and vocation. MCZ made several attempts to inculturate healing ministry; however, the western jacket that is worn by the church through a Eurocentric constitution became a centre of missio-cultural confrontation. This scenario has led MCZ to limp between Wesleyan tradition and African spirituality but remain neutral on the healing needs of their members. The researcher is convinced that the practice of taking the middle path by the MCZ in as far as healing is concerned is problematic and is a recipe for the church's division. If MCZ has to be relevant to its members in general and those in MEM in particular, the church has to embrace healing ministry. In doing this, there is need to come up with a well-defined theology, for example, the Catholics are particular about Extreme Unction while newer Pentecostal are using anointing oil. MCZ needs to define her own healing ministry theology. Since the three societies are all in Harare there are a three approaches that they can be used to inculturate healing ministry. First, MCZ should teach its members the basic theology of medicine, inculturation and medicalisation of healing ministry. Second, given that Zimbabwe continues to go down economically, the societies need to embark on herbal gardens as a way of having natural medicine. Third, spiritual and faith healing also need to be taught on all the society so that they will be in a position to differentiate exorcism from deliverance and how prayer and faith solve these spiritual problems

9.2 Contribution to New Knowledge

The research on the healing ministry, conflict and Methodism: the case of Mabelreign, Epworth and Mbare societies of the Methodist Church in Zimbabwe, has contributed to the global knowledge in a number of ways. First, this is a pioneering theological research in the MCZ. The few scholars who studied on Methodism at PhD level did not address this subject. Simon Madhiba researched on Methodism and politics, Kennedy Gondongwe focussed his research in the historical discipline investigating the consciousness and resistance of the indigenous clergy and Liberty Mawire researched on the continuity and discontinuities between the missionaries' worldview and that of the indigenous people. Second, the research on healing ministry is also unique in the Zimbabwean mainline churches in particular Tabona Shoko (2006) did some research in one Roman Catholic Church, in a peer-reviewed Journal. The research was not intensive and Shoko was also writing as an

outsider. Roman Catholic Church is not classified among the mainline churches thereby making this research unique. Third, most of the literature on healing ministry in the Methodist tradition is from the global north with scholars' like Maddox, Maddocks, Madden, Marquardt, and Hudes dominating the research space. No work has been done from the global south. Further to this point, the research was able to link the eighteenth century Wesleyan theology and the twenty first century MCZ understanding of healing ministry. Fourth the research brought to light the new discipline of historical-theology as it was attempting to make the two to negotiate to come out with an African flavour of healing ministry. Fifth, most of the literature on healing ministry in Zimbabwe is on African Initiated Churches. Since 2008, newer Pentecostal churches have stormed the research space with most scholars shifting their research interest to the new developments in these churches and how their healing ministry theology has influenced the religious space in Zimbabwe in particular. Sixth, the research has contributed to the broader knowledge of healing ministry theology given that it was also addressing the Africa, missionary and indigenous methods of healing.

9.3 Identifying Gaps for Further Research

Although this research is the first one from a local Methodist member and clergy, it has a number of limitations that call for further research in other areas. First, the research has only concentrated on three societies of the MCZ. Mabelreign society is in a circuit with a total of seven societies and only one was selected. Moreover, Mbare is in a circuit with three societies and only one was identified. The two societies are in Harare West District of the MCZ. Furthermore, Epworth society is in a circuit with seven other societies. Epworth circuit is in Harare East Districts. The fact that the research randomly selected societies in circuits with many other societies makes the research limited. Second, MCZ has a total number of eight districts and only two were selected. Using Harare East and West as examples, one will find that the three societies were not a representation of the MCZ. For example, Harare East has seventeen (17) circuits and one hundred and seventy-three (173) societies (MCZ Handbook 2017:88-91) and yet only one society was selected. In Harare West District, two societies were selected. The district has twenty-three (23) circuits and one hundred and fifty-eight (158) societies (MCZ Handbook 2017:91-94). A random selection of the two selected districts have shown that there are forty (40) circuits and three hundred and thirty-one societies (331) left out, thereby making the sample a

misrepresentation of the Methodist theology on the healing ministry. In addition, MCZ has 128 circuits (MCZ Handbook 2017:91-94) and only three societies from three circuits were identified.

Given these limitations, the other gaps that can be pursued are:

- i. Research on healing ministry from the ministers who practice this ministry and those who stand with the traditional background arguing that this is un-Methodist.
- ii. The superintendents who were interviewed were all male and middle aged. It is important to further pursue the same subject interviewing female ministers and elderly ministers.
- iii. Missio-cultural research on healing ministry in other languages like Ndebele will be important given that it is one of the major languages in Zimbabwe.
- iv. The researchers might also be interested in investigating the challenges and opportunities MCZ has to establish medical institutions.
- v. To reflect on Jesus' healing ministry in view of the healing ministry in the MCZ is also an important area that can be pursued with the aim of comparing the biblical healing ministry of Jesus and that of MCZ.

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APPENDICES ATTACHED

Appendix 1 – Ethical Clearance



25 April 2016

Rev. Martin Muringa 215000037
School of Religion, Philosophy and Classics
Pietermaritzburg Campus

Dear Rev. Muringa

Protocol reference number: HSS/0241/016D

Project Title: A Missio-Cultural Examination of the Healing Ministry within the Mabelreign, Mbare and Epworth Societies of the Methodist Church in Zimbabwe (MZC)

Full Approval – Expedited Application

In response to your application received 11 March 2016, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shenuka Singh (Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

Cc Supervisor: Professor Rodrick Hewitt & Dr Xolani Sakuba
Cc Academic Leader Research: Professor P Denis
Cc School Administrator: Ms Catherine Murugan

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: ximbap@ukzn.ac.za / snvmanm@ukzn.ac.za / mohunp@ukzn.ac.za

Website: www.ukzn.ac.za

1910 - 2010
100 YEARS OF ACADEMIC EXCELLENCE

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

Appendix 2 – Application Letter to the Methodist Church in Zimbabwe



UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

UNIVERSITY OF KWA-ZULU NATAL- PIETERMARITZBURG
School of Religion, Philosophy and Classics
Private Bag X01
Scottsville 3209
SOUTH AFRICA

10 November 2015

The General Secretary
Methodist Church in Zimbabwe
P.O Box CY 71
Causeway
HARARE

Dear Sir

RE: APPLICATION FOR PERMISSION TO HAVE ACCESS TO THE CHURCH
DOCUMENTS AND PERSONEL

I am writing to seek permission to cite Methodist Church in Zimbabwe documents, to use the church archives and to interview Superintendents and some members of Mabelreign, Mbare and Epworth Societies as I will be doing my PhD research on the topic : **A Missio-Cultural Examination of the Healing Ministry within the Mabelreign, Mbare and Epworth Societies of the Methodist Church in Zimbabwe (MCZ).**

Your favourable response will be greatly appreciated

Yours Sincerely

Martin Mujinga
UKZN PHD CANDIDATE

Appendix 3 – Permission from to the Methodist Church in Zimbabwe

THE METHODIST CHURCH IN ZIMBABWE CONNEXIONAL OFFICE



God's Agents of Transformation (Romans 12: 2)

Wesley House
17 Selous Avenue
Box Cy 71, Causeway
HARARE, Zimbabwe
Tel: +263-04-250523
Cell: 0712 360660/0712 613786
Email: methodist@mczconnexional.co.zw
Website: www.mczmethodist.org.zw

12 November 2015

Revd M. Mujinga
University of KwaZulu Natal Pieter Maritzburg
School of Religion, Philosophy and Classics
Private Bag X01
Scottsville 3209
South Africa

Dear Revd M. Mujinga

Application for permission to have access to the Church Documents and Personnel

We are in receipt of your application over the above matter that pertains to your research which requires you to use and enter our archives.

Permission is granted to you. We believe you will provide this office with your research tool and findings for the study.

Please indicate the period you will need to use the archives and the human documents in the mentioned circuits.

We wish you all the best as you add to knowledge on the topic:

A Missio-Cultural Examination of the Healing Ministry within the Mabelreign, Mbare and Epworth Societies of the MCZ.

Yours in Christ

Revd Dr. A.K. Nyanjaya
General Secretary

Appendix 4 – Informed Consent Letter



Social Sciences, College of Humanities,
University of KwaZulu-Natal,
Pietermaritzburg Campus,

Dear Participant

INFORMED CONSENT LETTER

My name is Martin Mujinga Student (215000037) I am a Systematic Theology PhD candidate studying at the University of KwaZulu-Natal, Pietermaritzburg campus, South Africa majoring in African Theology.

I am interested in learning about the relationship between mission and cultural understanding of the healing ministry within the Methodist Church in Zimbabwe (MCZ) with special reference to Mabelreign, Epworth and Mbare societies. My major interest in this study is to critically analyze the extent to which these MCZ societies respond to the healing needs of their members within the local context. The study seeks to involve the members of these societies both clergy and laity. To gather the information, I am interested in asking you some questions.

Please note that:

- Your confidentiality is guaranteed as your inputs will not be attributed to you in person, but reported only as a population member opinion.
- The interview may last for about 1 hour and may be split depending on your preference.
- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.
- Data will be stored in secure storage and destroyed after 5 years.
- You have a choice to participate, not participate or stop participating in the research. You will not be penalized for taking such an action.
- The research aims at knowing the challenges of your society relating to the missio-cultural understanding of the healing ministry and how that might be affecting the church.
- Your involvement is purely for academic purposes only, and there are no financial benefits involved.
- If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

	willing	Not willing
Audio equipment		
Photographic equipment		
Video equipment		

I can be contacted at: Email: martinmujinga@gmail.com

Cell: +263 772 207 033, or +27 78 589 5741 and +27 62 182 6718.

My supervisor is Prof Roderick Hewitt who is located at the School of Religion Philosophy and Classics, Pietermaritzburg campus of the University of KwaZulu-Natal.
Contact details - Hewitt@ukzn.ac.za Phone number: +27 33 260 6273

My Co-supervisor is Dr. Xolani Sakuba,
Systematic Theology, School of Religion Philosophy and Classics,
College of Humanities, University of KwaZulu-Natal, Pietermaritzburg Campus
(Tel) + 27 33 260 5850 (Cell) +27 71 301 8360, Email: Sakuba@ukzn.ac.za

You may also contact the Research Office through:
P. Mohun
HSSREC Research Office,
Tel: +27 31 260 4557 E-mail: mohunp@ukzn.ac.za

Thank you for your contribution to this research.

DECLARATION

I..... (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT

DATE

.....

.....

Appendix 5 – Letter to Superintendents of MEM Societies



School of Religion, Philosophy and
Classics
Private Bag X01
Scottsville 3209
SOUTH AFRICA

4 June 2016

To The Superintendents of:

Mabelreign Circuit- Rev K Paradza

Mbare Circuit- Rev V Chidzambwa

Epworth Circuit- Rev V Chakanya

RE: INTERVIEW SCHEDULE FOR MY PHD RESEARCH

Calvary greetings to you and the flock under your charge.

The PhD research topic I am studying entitled: **Healing Ministry, Conflict and Methodism: the case of Mabelreign, Epworth and Mbare societies of the Methodist Church in Zimbabwe** requires that I conduct in-depth semi-structured and focus group interviews on the experiences of the church leadership, members and some former Methodist members on the healing ministry phenomenon. Following this requirement, I applied for the permission to interview your office of the Superintendents to speak as the official voice of the church. I will also interview some church members from your society. The permission has been granted by the church.

The interviews will be divided into two categories namely the in-depth interview and focus group interviews.

On one hand, the in-depth interview will be conducted in the order:

- i. The Superintendent
- ii. Senior Society Steward/s
- iii. Two Ruwadzano/ Manyano leader
- iv. One MCU leader from each society

On the other hand, the focus group interviews will be conducted with:

- i. The youth- As you are helping me to identify the youth, I prefer those between **18-25 years who have more than two years** in the church because they are young adults and they have their consent to respond to questions.
- ii. Church members
- iii. Former Methodist members.

Each group is expected to have **6-10 people** preferably equal number of both sexes to balance the discussion.

The second focus group of church members divided into two categories of the “rich” and the “poor”. **These members should have more than five years in the church.** The two groups are expected to respond differently on the healing ministry phenomenon. The numbers should also be the same as above with the equal number of male and female if it is possible.

The last focus group is of the **former Methodist members**. I know these people might not be easy to find, but I request your assistance through the church leaders to identify them (Snowball sampling).

The interviews take one to one and half hours. If need be the interviews will be conducted more than once.

I have attached:

- i. The semi-structured interview schedule
- ii. Focus group interview schedule
- iii. Informed consent letter
- iv. My application letter to the Church seeking the permission
- v. The church's response to my letter
- vi. The Ethical Clearance

The reason for attaching these documents is to appraise you with the requirements of the study.

For any further clarifications, you can contact me at martinmujinga@gmail.com, or on my mobile numbers, +27 78 589 5741, +27 62 182 6718 or +263 77 220 7033 .

Yours Sincerely



Martin Mujinga (Rev) (215000037)
PHD CANDIDATE (UKZN)

Cc

The Presiding Bishop	Rev Dr S Zwana
General Secretary	Rev Dr J Dube
Harare East District Bishop	Rev R Ncube
Harare West Bishop	Rev T Sungai

Appendix 6 – In-depth Individual Interviews

In-depth semi-structured interview schedules was used to gather information from the church leaders of MEM societies. Sixteen participants who represents the official voice of the church. These participants are: the superintendents of the three societies, Senior Stewards, RM (female organization) leaders and Men's Christian Union (MCU) (male organization)

MABELREIG SOCIETY			
	Office	Name of Participant	Date
1	Superintendent	Rev Kudakwashe Paradza	23/06/16
2	Senior Stewards	Mr Stanley Mandizha (Shona)	15/6/16
		Mr Tichaona Viyazhi (English)	
3	Ruwadzano/ Manyano Chairwomen	Auxilia Tsitsi Chipere (Ruwadzano A- Thursday)	15/6/16
		Lina Pasipamire (Ruwadzano B-Saturday)	
4	MCU Chairman	Philemon Pasipamire	15/6/16

EPWORTH SOCIETY

	Office	Name of Participant	Date
1	Superintendent	Rev Victor Chakanya	15/6/16
2	Senior Steward	Mercy Nota	21/6/16
3	Ruwadzano/ Manyano Chairwomen	Rebecca Mudzamiri (Ruwadzano A- Thursday)	21/6/16
		Muriel Molife (Ruwadzano B-Saturday)	
4	MCU Chairman	Gabriel Mazivanhanga	31/8/16
MBARE SOCIETY			
	Office	Name of Participant	Date

1	Superintendent	Rev Victor Chidzambwa	11/6/16
2	Senior Steward	Fricano's Mupakwachena	11/6/16
3	Ruwadzano/ Manyano Chairwomen	Vongai Priscilla Gonye (Ruwadzano A- Thursday)	16 /6/16
		Mavis Govhati (Ruwadzano B-Saturday)	
4	MCU Chairman	Edmore Nhire	19/6/16

QUESTIONS THAT WERE ASKED DURING THE SEMI-STRUCTURED INTERVIEWS

Section A. Understanding the missional phenomenon of healing ministry

1. How does Methodist Church in Zimbabwe define healing ministry?
2. Has the healing ministry been practiced in the Methodist Church in Zimbabwe before?
 - a. If yes, how has it been practiced?
 - b. If no why it was not practiced?
3. Is the healing ministry being practiced today and what are its impact to your society?
4. To what extent is the healing ministry part of the MCZ's mission strategy?
5. What are the socio-cultural factors affecting healing ministry in MCZ?
6. Do people seek healing in the Methodist Church?
 - a. If yes, who does the healing service and why?
 - b. If no where do they seek this ministry?
7. What is the church's understanding of healing ministry?
8. Does your society have programmes for the healing ministry in place?
 - a. If yes how are they structured and who run the programmes and where are these services conducted?
 - b. If no what is the church doing do have such programmes?
9. When are the services conducted and why?
10. Does the church have literature on healing ministry?
 - a. If yes is this literature locally oriented, is it in vernacular language, how does the literature relates to the current healing needs of the society?
 - b. If no, what action is the church taking to make sure that they have locally oriented literature that can be read by every member in the church?

11. Has there been an occasion when members demand healing in the church? How did the church reacted?
12. Are there any challenges that the church is facing with regard to the healing ministry?
13. How is the Methodist Church at your society responding to the external forces on the healing phenomenon like:
 - a. African Traditional Religion
 - b. Catholic Church
 - c. African Initiated Churches
 - d. Pentecostal Churches/ Neo Pentecostal Churches
 - e. Medical healing

Section B. Inculturation

1. Are there any possibilities of inculturating healing ministry in the Methodist Church in Zimbabwe?
 - a. If yes what can be the best way to do it?
 - b. If no what can be the reasons?
2. Are there some reasons why healing ministry should be inculturated in the Methodist Church?
3. What are the benefits of inculturating healing ministry in the MCZ?
4. What are the merits of inculturating healing ministry at your society?
5. Are there any challenges of inculturating healing ministry in MCZ or at your society?
6. What is the demerit/s of MCZ not inculturating healing ministry in the face of external forces offering this ministry?
7. Has your society been advocating for inculturation of the healing ministry?
 - a. If yes what could have been the pushing factors?
 - b. If no what were the reasons?
9. If it happens that some members demand healing at the church, how does the church respond?
10. Did your society ever discussed ways of inculturating the healing ministry?

Thank you for participating in this interview

Appendix 7 – In-depth Focus Group Interviews

Semi-structured focus group interviews are questioning route that were used during the focus group discussions to the Methodist Church in Zimbabwe three selected societies of MEM. The interviews were used to interview 12 focus groups with four (4) groups coming from each society. These participants constitute the ordinary members of the church who represents the voice of the voiceless. The four groups comprise of:

- i. The first group comprised the **YOUTH** between the ages of 18-25, who have been in the church for more than two years who were selected using the random sampling. Below is the schedule of the selected youth from the three societies.

MABELREIGN SOCIETY Date – 16 June 2016			EPWORTH SOCIETY Date 26 June 2016			MBARE SOCIETY Date 19 June 2016		
Venue – Mabelreign MCZ			Venue- Epworth MCZ			Venue – Mbare MCZ		
Participants	Male	Female	Participants	Male	Female	Participants	Male	Female
10	5	5	8	4	4	10	5	5

- ii. The second group comprise of (2) categories of people, the privileged and the less privileged in each society selected using random sampling.

- a. Schedule of participants drawn from the **“RICH”** people of the three societies

MABELREIGN SOCIETY Date – 7 July 2016			EPWORTH SOCIETY Date 26 June 2016			MBARE SOCIETY Date 19 June 2016		
Venue – Mabelreign MCZ			Venue- Epworth MCZ			Venue – Mbare MCZ		
Participants	Male	Female	Participants	Male	Female	Participants	Male	Female
7	4	3	9	3	6	8	3	5

- b. Schedule of participants drawn from the less privileged people of the three societies

MABELREIGN SOCIETY Date – 7 July 2016			EPWORTH SOCIETY Date 29 June 2016			MBARE SOCIETY Date 19 June 2016		
Venue – Mabelreign MCZ			Venue- Epworth MCZ			Venue – Mbare MCZ		
Participants	Male	Female	Participants	Male	Female	Participants	Male	Female
9	4	5	10	5	5	9	4	5

iii. FORMER METHODIST MEMBERS

The last category comprised people who were once members of the Methodist Church and have since migrated out. These people were selected using the snowball sampling method. Some were interviewed as a group while others were interviewed as individuals.

- a. A total of **four** people comprising three male and one female former **MABELREIGN METHODIST** members were interviewed.

Interviewee -Mabelreign A “MA”	Interviewee -Mabelreign B “MB”	Interviewee Mabelreign C “MC”
Date – 30 August 2016	Date – 30 August 2016	Date – 31 August 2016
Venue – Belvedere- Harare	Venue – Zimre Park – Harare	Venue – Mabelreign
One male now a member of the Harvest International Ministries	One couple now back in the Methodist Church in Zimbabwe. The couple moved out and attended United Family International Church, Prophetic Healing and Deliverance Ministries and Heart Felt Ministries in a space of three years	One male now attending Christ Embassy

A total of **four** people comprising of two male and two female former

MBARE Methodist members were interviewed.

Participants from Mbare Methodist Church

Date – 30 August 2016

Venue – Highfield Harare

Two couples were interviewed as a focus group. Couple “A” is now attending the United Family International Church while couple “B” is now with the Prophetic Healing and Deliverance Ministries

- b. A total of **four** people comprising three female and one male former **EPWORTH** Methodist members were interviewed.

<u>Interviewee “EA” (Epworth)“</u>	<u>Interviewee “EB” (Epworth B)“</u>	<u>Interviewee “EC” (Epworth C)“</u>
Date -30 June 2016	Date -4July 2016	Date -4 September 2016
Venue – Epworth	Venue – Epworth	Venue – Hatfield
Participants	Participants	Participants
One female now attending Johane Masowe ye Chishanu	One female now attending United Family International Church	One couple now attending the United Methodist Church

INTERVIEW QUESTIONS THAT WERE ASKED TO THE FOCUS GROUPS

Section A. Understanding and Practice

1. What is your understanding of healing ministry?
2. Does the Methodist Church practice the healing ministry?
3. What are the benefits of practicing healing ministry in the church?
4. What are the challenges of not practicing healing ministry in the church?
5. Are there some external forces that are pushing MCZ to respond to the healing ministry?
 - a. If yes, how has this been experienced by both the church leadership and the ordinary members of the church?

Section B. Inculturation

1. Should the Methodist Church in Zimbabwe practice cultural healing?
 - a. If yes, how will this action not contradict the mission?
 - b. If no how should MCZ strike a balance between her mission and cultural identity?
2. Is it possible to use the cultural ways of healing in the Methodist Church?
 - a. If yes how should it be done?
 - b. If no what could be the challenges?
3. If any member of the MCZ needs healing, should the church refer him/her to other healers outside MCZ?
 - a. If yes, what are the merits of taking such an action?
 - b. If no, how should Methodist Church respond to such a need?
4. Has any member in MCZ demanded healing? Was healing performed in the cultural way?
 - a. If yes, what actually happened?
 - b. What were the feelings of the other members of the church to this performance?
5. What should the church do in order to respond meaningfully to healing ministry?
6. What can the MCZ do to get back its members who have left the church in search of healing elsewhere? (question for the fourth category)

Thank you for your participation

Appendix 8 – Letter to the National Archives of Zimbabwe



30 August 2016

National Archives of Zimbabwe
Harare

To Whom It May Concern

RE: REQUEST TO USE THE NATIONAL ARCHIVES FOR MY PhD RESEARCH


Dear Sir/Madam

My name is MARTIN MUJINGA (ID 43-100643 Z 43). I am a PhD candidate at the University of Kwa-Zulu Natal, Pietermaritzburg campus, South Africa since 2015. I am studying Systematic Theology and my topic is, A *Missio-Cultural Examination of the Healing Ministry within Mabelreign, Mbare and Epworth Societies of the Methodist Church in Zimbabwe*.

My research includes semi-structured interviews and visiting the archives as methods of data collection. I have written to the Methodist Church in Zimbabwe to seek permission and I was granted, however, some of the information I want about the project for example, Mai Chaza and Ernest Paul Mwazha the former Methodist members are minimal in the church archives.

I can be contacted on martinmujinga@gmail.com or +263 772 207 033 or +27 78 589 5741. My supervisors are Prof Roderick Hewitt and Dr. Xolani Sakuba, both located at the School of Religion Philosophy and Classics, Pietermaritzburg campus of the University of KwaZulu-Natal. Their contact details are Hewitt@ukzn.ac.za, (Tel) +27 33 260 6273 and Sakuba@ukzn.ac.za (Tel) +27 33 260 5850. You may also contact the Research Office through: P. Mohun HSSREC Research Office, Tel: +27 31 260 4557 E-mail: mohunp@ukzn.ac.za

Yours Faithfully



Martin Mujinga
PhD Candidate (215000037)

Appendix 9 – Response from the National Archives of Zimbabwe

A3151312

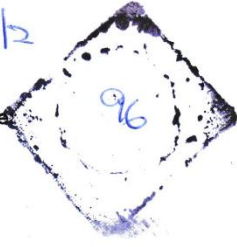
All communications to be addressed to
"THE DIRECTOR"

Telephone: 792741-3
Fax: 263-04-792398
E-Mail: archives@archives.gov.zw


ZIMBABWE
NATIONAL ARCHIVES OF ZIMBABWE

In reply please quote

Private Bag 7729
Causeway
Zimbabwe



31 August 2016

Social Science, College of Humanities
University of Kwazulu-Natal
Pietermaritzburg Campus
Republic of South Africa

ATT: Martin Mujinga (PhD Candidate)

REF: REQUEST TO USE THE NATIONAL ARCHIVES FOR PhD RESEARCH

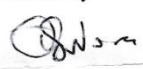
The above refers.

Please be advised that the Director of the National Archives of Zimbabwe (NAZ) has no objection to your research request. The National Archives is open from 0830 to 1600 during the week. We do not open during weekends and public holidays. For Zimbabwean citizens positive identification and a search fee of \$1 per individual per day is required. We also offer photocopying services at \$1 for five A4 pages up to a maximum of 25 pages per individual per week. A one third rule applies to all library material.

You are also required to deposit a copy of your final research with us as acknowledgement. In the event that you use NAZ photographs and you intend to publish your research findings we advise that you do it in consultation with NAZ so that agreements for editorial fees can be made before the publication of the final research product.

I wish you well in your studies.

Sincerely


T. Chigodora
FOR DIRECTOR

Sent by Email.

Appendix 10 – Letter to Seth Mokitimi Methodist Seminary Library / Archives



UNIVERSITY OF KWA-ZULU NATAL- PIETERMARITZBURG
School of Religion, Philosophy and Classics
Private Bag X01
Scottsville 3209
SOUTH AFRICA

13 September 2016

The Head Librarian
Seth Mokitimi Methodist Seminary
Golf Road
Pietermaritzburg
RSA

Dear Sir

RE: APPLICATION FOR PERMISSION TO USE THE SETH MOKITIMI METHODIST
SEMINARY LIBRARY AND ARCHIVES

My name is Martin Mujinga student number 215000037. I am a PhD candidate at the University of KwaZulu Natal – Pietermaritzburg Campus from 2015. I am in the School of Religion, Philosophy and Classics, in the area of Systematic Theology. I am researching on the topic: **A Missio-Cultural Examination of the Healing Ministry within the Mabelreign, Mbare and Epworth Societies of the Methodist Church in Zimbabwe (MCZ)**. I am therefore writing to seek permission to have access to the Seth Mokitimi Methodist Seminary library and archives on the information about John Wesley's view on the healing ministry and the history of Methodism to South Africa and Zimbabwe.

I can be contacted at: Email: martinmujinga@gmail.com Cell: +27 78 589 5741 and +27 62 182 6718. My supervisor is Prof Roderick Hewitt and the Co-supervisor is Dr. Xolani Sakuba, who are located at the School of Religion Philosophy and Classics, Pietermaritzburg campus of the University of KwaZulu-Natal. Their contact details are Hewitt@ukzn.ac.za. Phone number: +27 33 260 6273 and Sakuba @ukzn.ac.za (Tel) + 27 33 260 5850. You may also contact the Research Office through: P. Mohun HSSREC Research Office, Tel: +27 31 260 4557 E-mail: mohunp@ukzn.ac.za

Your favourable response will be greatly appreciated

Yours Sincerely


Martin Mujinga
UKZN PHD CANDIDATE

Cc – SMMS President – Rev Prof S.R Kumalo
SMMS Dean of Studies -Dr R Marie

Appendix 11 – Letter from Seth Mokitimi Methodist Seminary



SETH MOKITIMI METHODIST SEMINARY
Forming Transforming Leaders for Church and Nation
www.smms.ac.za

Revd. Martin Mujinga
University of KwaZulu-Natal
School of Religion, Philosophy and Classics
Private Bag X01
Pietermaritzburg 3209
South Africa

15 September 2016

Dear Sir,

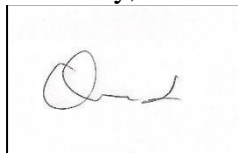
RE: Application for permission to use the Seth Mokitimi Methodist Seminary Library and Archives

Your letter of 13 September 2016 pertaining to the above subject matter has reference.

We hereby grant you permission to use the Seth Mokitimi Methodist Seminary (SMMS) library and archives in order to have access to the information on John Wesley's views on the healing ministry and the history of Methodism in South Africa and Zimbabwe. This permission is contingent on compliance with the policies and rules of the SMMS library.

Please give me a call on the number provided below should you require any further information or have any questions concerning this matter.

Sincerely,



Ken Chisa

Head Librarian


Cc: SMMS President - Prof. SR Kumalo
SMMS Dean of Studies – Dr. R Marie
Librarian – Miss Ntombifuthi NLLiampni

Appendix 12 – Epworth, Easter Programme

MT 6:14-15

TIME	ITEM	FACILLITATOR
08:30-09:30	PRAYER AND FASTING	REV J. CHAKANYA
09:30-10:00	PRAISE	VASHUMIRI GROUP
10:00-10:30	TEA BREAK	ALL
10:30-10:45	PRAISE	YOUTHS
10:45-11:45	FORGIVENESS	REV M. MUJINGA
11:45-12:00	PRAISE	VASHUMIRI
12:00-13:00	LIFE AFTER EASTER	REV MOYO
13:00-14:00	LUNCH	ALL
14:00-14:15	PRAISE	MESSENGERS OF HEAVEN
14:15-15:15	UNITY IN THE FAMILY OF GOD	DISTRICT BISHOP
16:15-17:00	VHUSERE	GOROMONZI CO-ORDINATOR
17:00-18:00	FEEDBACK	GROUP LEADERS
18:00-18:30	PRAISE	THE REDEEMED
18:30-20:00	REFRESHMENTS & SUPER	ALL
20:00-20:30	PRAISE	GORMONZI MUSIC GROUP
20:30-23:45	HEALING AND DELIVERANCE	REV CHAGUNDUMA
23:45-00:15	BREAK	ALL
00:15-00:45	PRAISE	YOUTHS
00:45-01:45	SERVICE	CO-ORDINATORS
01:45-03:00	GROUP & INDIVIDUAL PRESE	MAI ZVANJANIA
03:00-04:00	TESTIMONIES	SISTER RUTH DZIKITI
04:00-06:30	RUMUKO & MORNING	RUWADZANO
06:30-08:00	PRAISE	ALL
08:00-08:00	SERMON & HOLY COMMUN	REV M. MUJINGA
09:00-10:00	BREAKFAST & DAPARTURE	ALL

THE METHODIST CHURCH IN
ZIMBABWE



EPWORTH, MABVUKU &
GOROMONZI CIRCUITS

EASTER CRUSADE
2016

THEME: THROUGH CALVARY'S GRACE GOD IS WITH US ALL
THE TIME: ISAIAH 43 VS 2.

DATE: 24TH TO THE 27TH OF MARCH 2016
VENUE: RUSIKE SECONDARY SCHOOL

DAY 1: THURSDAY

TIME	ITEM	FACILITATOR
16:00-18:00	ARRIVAL AND REGISTRATION	SECRETARIES
18:00-18:30	DEVOTIONS	MABVUKU CIRCUIT
18:30-19:00	WELCOME AND INTRODUCTIONS	GOROMONZI CIRCUIT STEWARD
19:00-20:00	SUPPER	ALL
20:00-22:00	COMMUNION SERVICE	REV MOYO
22:00-22:30	BEDTIME	ALL

DAY TWO FRIDAY

TIME	ITEM	FACILITATOR
05:00-06:00	PRAYER TIME	MRS JUMBE
06:00-06:30	MORNING DEVOTION	GOROMONZI CIRCUIT
06:30-07:30	BREAKFAST	ALL
07:30-08:00	PRAISE & WORSHIP	ALL
08:00-09:00	MEANING OF THE CROSS	REV S. GONDRE
09:00-09:05	PRAISE	
09:05-10:05	SPIRITUAL GROWTH	REV V. CHAKANYA
10:05-10:30	TEA BREAK	ALL
10:30-11:00	PRAISE	EPWORTH YOUTH GROUPS

MASTERS OF CEREMONY

1. CLIFF TAKURA
2. MR MUTODZA
3. MUNYARADZI KAVHAYI
4. WELLINGTON BUTAU
5. MR MARAMBANHAKA
6. MOLLEN TAMBUDZAYI
7. MRS KORE
8. GOROMONZI CIRCUIT

DAY TWO: FRIDAY

TIME	ITEM	FACILITATOR
11:00-12:00	AMAZING GRACE	REV CHINYERERE
12:00-13:00	ENTERTAINMENT	ALL CHOIR GROUPS
13:00-14:00	LUNCH	ALL
14:00-14:30	PRAISE	MANDARAZI FAMILY MUSIC GROUP
14:30-15:00	ENTERTAINMENT	DOMBORAMWARI REVIVAL
15:00-17:00	SERVICE (7 WORDS)	PREACHERS
17:00-17:30	PRAYER TIME	MRS MBERI
18:30-17:30	ENTERTAINMENT	GROUP
17:30-18:30	SERMON	YOUTH GROUPS
18:30-19:30	SUPPER	ALL
19:30-20:30	PRAYER TIME	BROTHER TAPIWA GORONGA
20:30-21:30	EVENING SERVICE	M.C.U
21:30 -22:00	GIVING & OFFERING	TREASURER
22:00-22:15	ANNOUNCEMENTS & BENEDICTION	GOROMONZI CO-ODINATOR
	BEDDING TIME	ALL
	DAY : SATURDAY	
05:00-06:00	PRAYER TIME	MRS YASI
06:00-06:30	PRAISE	ALL
06:30-07:00	DEVOTIONS	EPWORTH CIRCUIT
07:00-08:00	BREAKFAST	ALL
08:00-08:30	PRAISE	ALL

Appendix 13 – Mabelreign Easter Programme

THE METHODIST CHURCH IN ZIMBABWE MABELREIGN @ WARREN PARK CIRCUITS EASTER PROGRAMME

Dates 17-20 April 2014

Venue Moleli High School

Theme: ***Without the Shedding of the Blood, there is no remission “Heb9:22”***

TIME	ACTIVITY	FACILITATOR	PRESENTER
Thurs 17 April			
		MCs Mr Chigodora and Ms Bhala	
1400-1800	Arrival		
1800-1900	SUPPER		
1900-1930	Praise for Worship	Mrs Chimonyo and Mrs Musasa (WP)	Praise Team
1930-2000	Welcome and introductions		Mr Ziso/Mr Mudariki
2000-2130	Holy Communion Service		Rev G Magwera
2130-2200	Announcements & Bed Time		
Fri 18 April			
		MCs – Mr Musarurwa and Mrs YB Murahwa	
0400-0600	Individual prayer time		
0600-0630	Devotions		Warren Park
0630-0730	BREAKFAST		
0730-0800	Praise for Worship	Mrs Chimonyo / Mrs Musasa (WP)	Praise Team
0800-0930	The Cross and Crucifixion		Rev M Mujinga
0930-1000	Praise for Worship		Praise Team
1000-1030	Break		
1030-1100	Youth Presentations		
1100-1230	Meaning and Significance of Easter		Rev B Lombard
		MCs - Mr Gandashanga and Mrs Madamombe	
1230-1400	LUNCH		
1400-1430	Praise for Worship	Mrs Chimonyo and Mrs Musasa (WP)	Praise Team
1430-1600	The Seven Words on the Cross		Preachers
1600-1630	Break		
1630-1800	Repentance		Rev M Hokonya
1800-1830	Prayer Time		
1830-2000	SUPPER		

2000-2030	<i>Praise for Worship</i>	<i>Mrs Chimonyo and Mrs Musasa (WP)</i>	<i>Praise Team</i>
2030-2130	<i>Evening Service</i>		<i>Rev I Chisenwa</i>
2130-2200	<i>Notices</i>		
2200	<i>Bed Time</i>		
<i>Sat 19 April</i>		<i>MCs- Mr Chawurura and Mrs Makusha</i>	
0400-0600	<i>Individual prayer time</i>		
0600-0630	<i>Devotions</i>		<i>Mabelreign</i>
0630-0730	<i>BREAKFAST</i>		
0730-0800	<i>Praise for Worship</i>	<i>Mrs Chimonyo and Mrs Musasa (WP)</i>	<i>Praise Team</i>
0800-0900	<i>Meaning and significance of the Blood of Jesus</i>		<i>Rev M Mujinga (Mrs)</i>
0900-0930	<i>Praise for Worship</i>	<i>Mrs Chimonyo and Mrs Musasa (WP)</i>	<i>Praise Team</i>
0930-1030	<i>Why Did Jesus Die?</i>		<i>Rev M Mujinga</i>
1030-1100	<i>Men's Presentations</i>		
1100-1230	<i>Forgiveness</i>		<i>Rev Dr A Nyanjaya</i>
		<i>MCs Mrs Pasipamire and Mrs Njovu</i>	
1230-1400	<i>LUNCH</i>		
1400-1430	<i>Praise for Worship</i>	<i>Mrs Chimonyo / Mrs Musasa (WP)</i>	<i>Praise Team</i>
1430-1630	<i>Healing and Deliverance Service</i>		<i>Rev M Ncube</i>
1630: 1730	<i>Choir presentations</i>		
1730-1830	<i>Grace</i>		<i>Bishop T Sungai</i>
1830-2000	<i>SUPPER</i>		
2000-2030	<i>Praise for Worship</i>	<i>Mrs Chimonyo / Mrs Musasa (WP)</i>	<i>Praise Team</i>
2030-2130	<i>Evening Service</i>		<i>Rev L Mabude</i>
2130-2200	<i>Notices</i>		
2200	<i>Bed Time</i>		
<i>Sun 20 April</i>		<i>MCs Masvanhise and Mrs Musasa (Mabel)</i>	
0400-0600	<i>Witness of Resurrection</i>		<i>Ruwadzano/ Manyano</i>
0600-0630	<i>Praise for Worship</i>	<i>Mrs Chimonyo / Mrs Musasa (WP)</i>	<i>Praise Team</i>
0630-0800	<i>Resurrection Service</i>		<i>Rev K Paradza</i>
0800-0815	<i>Vote of Thanks</i>		<i>Mr Ziso/ Mr Mudariki</i>
0815-	<i>Clean up Breakfast and departure</i>		

“As we return home lets walk in the light and life of the resurrected Christ”

Appendix 14 – Mbare Circuit 2015 and 2016 Easter Programmes

MCZ MBare Circuit

Crusade yerwendo

RINDAI MUCHINYENGETERA: MATT 26:41

27 MARCH 2015

VAVAMBI CHURCH

PROGRAM

2000	Huyai tirumidze Ishe Wamatenga	
2030	Devotions	Mrs P.Gondongwe
2100	Welcome and introductions	Mr A.Takadiyi & Rev V.Chidzambwa
2130	Rauya vhangeri	Rev O.Musekiwa
2230	Torumbidza Ishe	
2300	Vhangeri riya raputika	Rev V.Chidzambwa
	Deliverance	
	Vote of thanks	Mrs Nyandoro

**M C Z MBARE CIRCUIT
ALL NIGHT PRAYER
22 JULY 2016**

Luke 1:38 Ndiri mwana wenyu ndiitirwe hangu zvakanaka

Programe

2000	Praising	
2030	Rauya shoko	Rev Matemba
2130	Sermon	Rev O.Musekiwa.
2030	Healing	Rev Makuvaza